

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 11501	
G-635				72 11501	
BIRTH NO.				STATE OF MARYLAND-DEMD	
1. NAME OF DECEASED (Type or Print) <b>Gardner, Rufus Morgan</b>			2. DATE AND HOUR OF DEATH <b>12/3/72</b> <b>2:00 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Pleasant Manor Nursing Home 4615 Park Heights Avenue Baltimore, Maryland 21215</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Baltimore</b> B. COUNTY <b>1303</b> C. CITY OR TOWN <b>Maryland</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1111 Whitelock Street</b>		
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>	8. DATE OF BIRTH <b>12/25/98</b>	9. AGE (In years last birthday) <b>73</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>	
13. FATHER'S NAME <b>Unknown</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Unknown</b>			16. SOCIAL SECURITY NO. <b>216-10-2936</b>		17. INFORMANT <b>Earl Gardner, 5392 Mad River Lane</b>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>4123 I</b> <b>Broncho-pneumonia</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Cerebral Thrombosis</b> <b>Arteriosclerotic Heart Disease</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>3 days</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>1 week</b> (C) <b>1 year</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>none</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>July 3 1971</b> to <b>Dec 3 1972</b> that (I) (we) last saw the deceased alive on <b>Dec 3 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Manuel Levin M.D.</b>			23B. DATE SIGNED <b>12/3/72</b>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <b>Manuel Levin</b>			23D. ADDRESS <b>6101 Park Heights Avenue</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12-7-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>ARBUTUS MEMORIAL PARK</b>	
24D. LOCATION <b>BALTIMORE, MARYLAND</b>		24E. NAME OF REGISTRAR <b>DEC 5 1972</b>			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR <b>MORTON &amp; DYETT</b>	
25D. ADDRESS <b>1701 LAURENS ST</b>					

11. 11. 11.

11. 11. 11.

11. 11. 11.

11. 11. 11.

11. 11. 11.

11. 11. 11.

11. 11. 11.

11. 11. 11.

11. 11. 11.

11. 11. 11.

11. 11. 11.

11. 11. 11.

11. 11. 11.

11. 11. 11.

11. 11. 11.

11. 11. 11.

11. 11. 11.

11. 11. 11.

11. 11. 11.

11. 11. 11.

11. 11. 11.

11. 11. 11.

11. 11. 11.

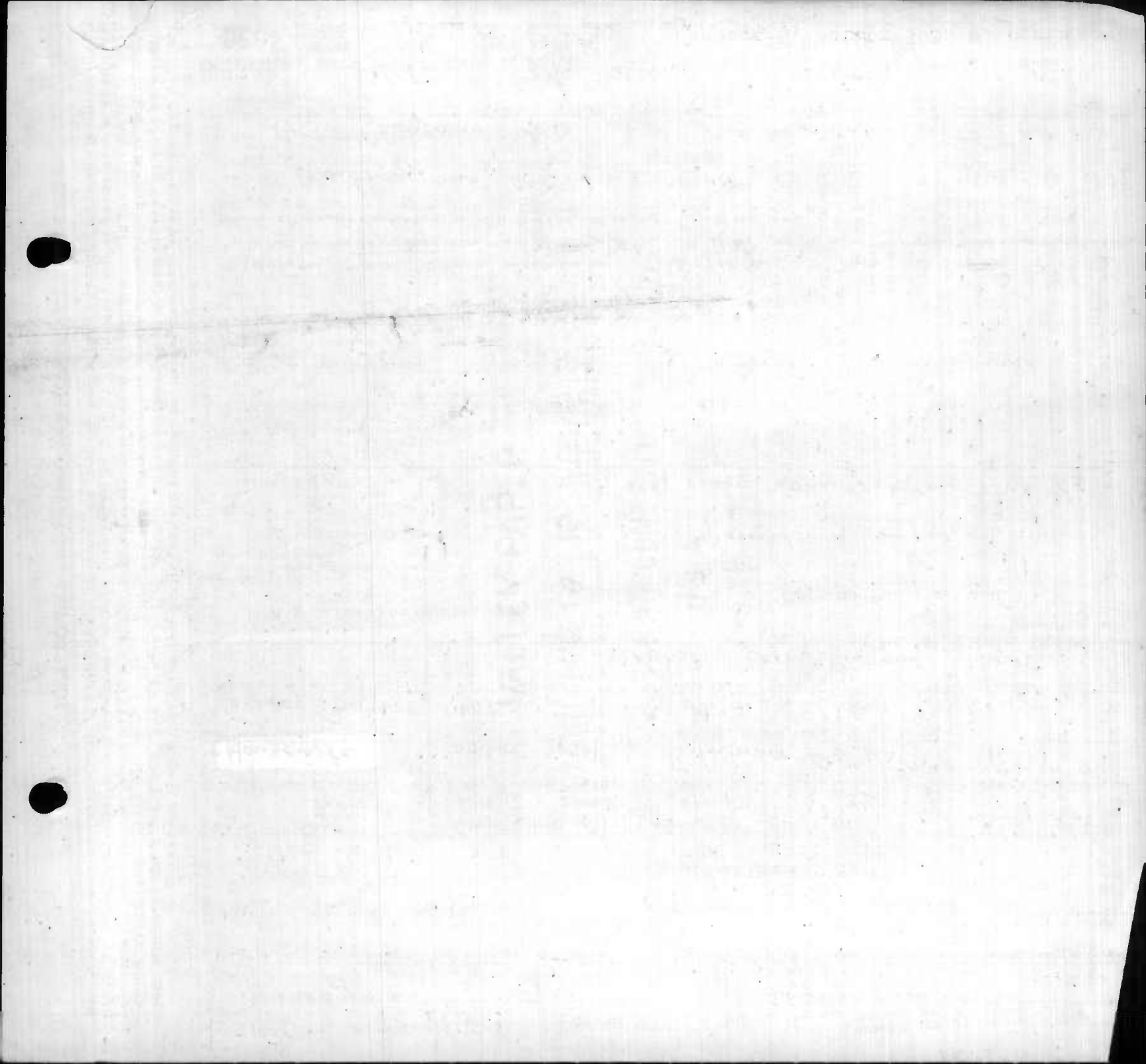
11. 11. 11.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

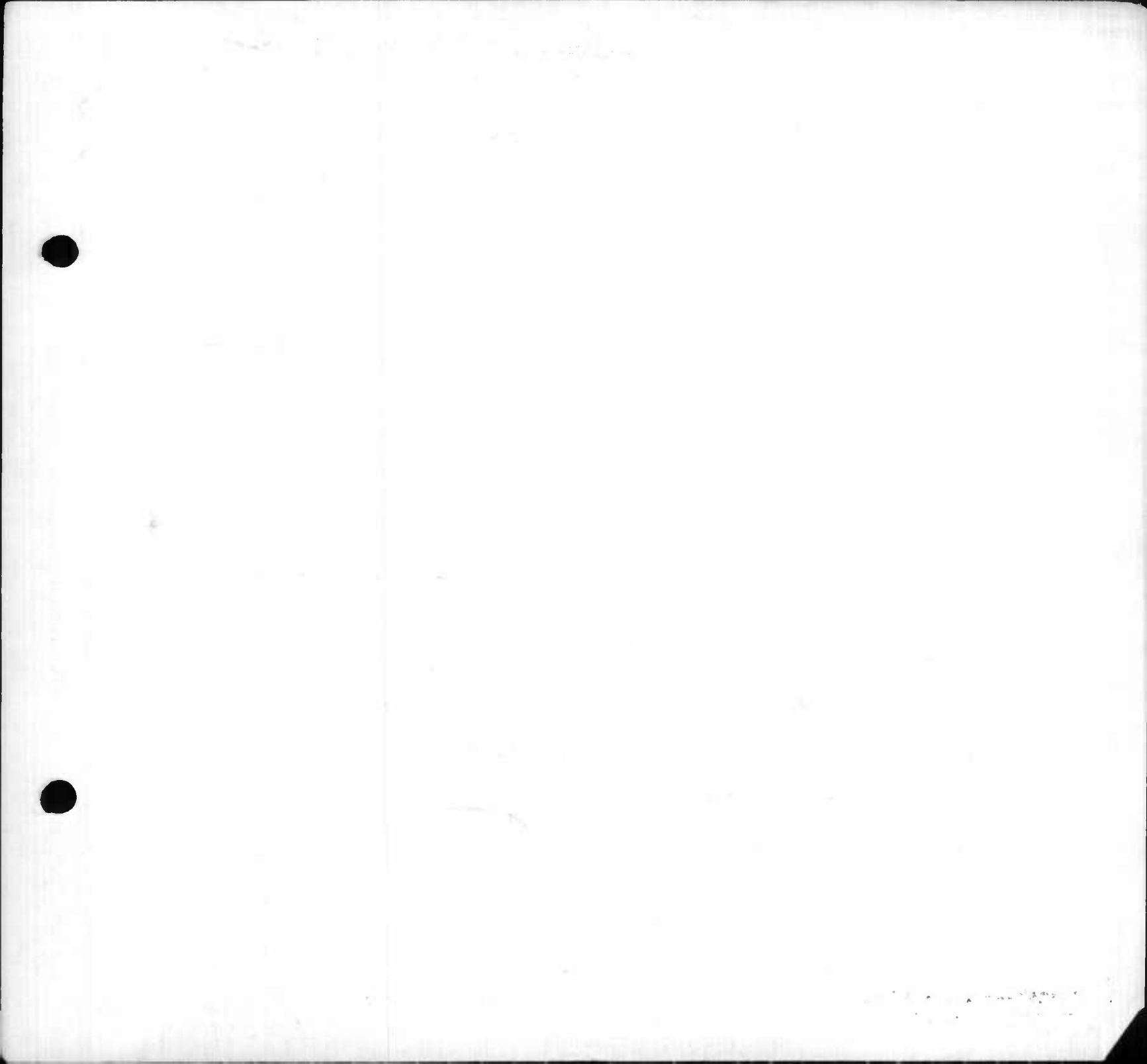
B-653		72 11502		BALTIMORE CITY HEALTH DEPARTMENT		12 11502	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Bryant, Admorio, Marionette</u>				2. DATE AND HOUR OF DEATH <u>3 December 1972</u> <u>12 30 P</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) <u>MARYLAND</u> <u>BALTO</u> <u>530</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Sinai Hospital</u> <u>Baltimore MD 21215</u>				C. CITY OR TOWN <u>Baltimore MD</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER <u>6705 Wilmont Drive</u>			
5. SEX <u>F</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/16/39</u>	9. AGE (In years last birthday) <u>33</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done in most of working life, even if retired) <u>Secretary</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>State of Alaska</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore MD USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Thomas Askew</u>				14. MOTHER'S MAIDEN NAME <u>Marion Odell Dickens</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>219 26 9986</u>		17. INFORMANT <u>hsb. Leroy Vincent Bryant</u>	
				ADDRESS <u>6705 Wilmont Drive</u>			
18. <u>734.11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>respiratory arrest</u>  (B) DUE TO, OR AS A CONSEQUENCE OF: <u>pneumonia, empyema</u>  (C) DUE TO, OR AS A CONSEQUENCE OF: <u>systemic lupus erythematosus</u>			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>0</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>2 October</u> 19 <u>72</u> to <u>3 Dec</u> 19 <u>72</u> , that (I) (we) last saw the deceased alive on <u>3 Dec</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Gian Caggiano M.D.</u>						23B. DATE SIGNED <u>3 December 1972</u>	
23C. PHYSICIAN'S NAME (Type) <u>Gian Caggiano M.D.</u>						23D. ADDRESS <u>Sinai Hospital Balto MD 21215</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>12/8/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Baltimore National</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 5 1972</u>				25B. NAME OF REGISTRAR <u>Herbert E. Nutter</u>		25C. FUNERAL DIRECTOR ADDRESS <u>3035 W. North Ave</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

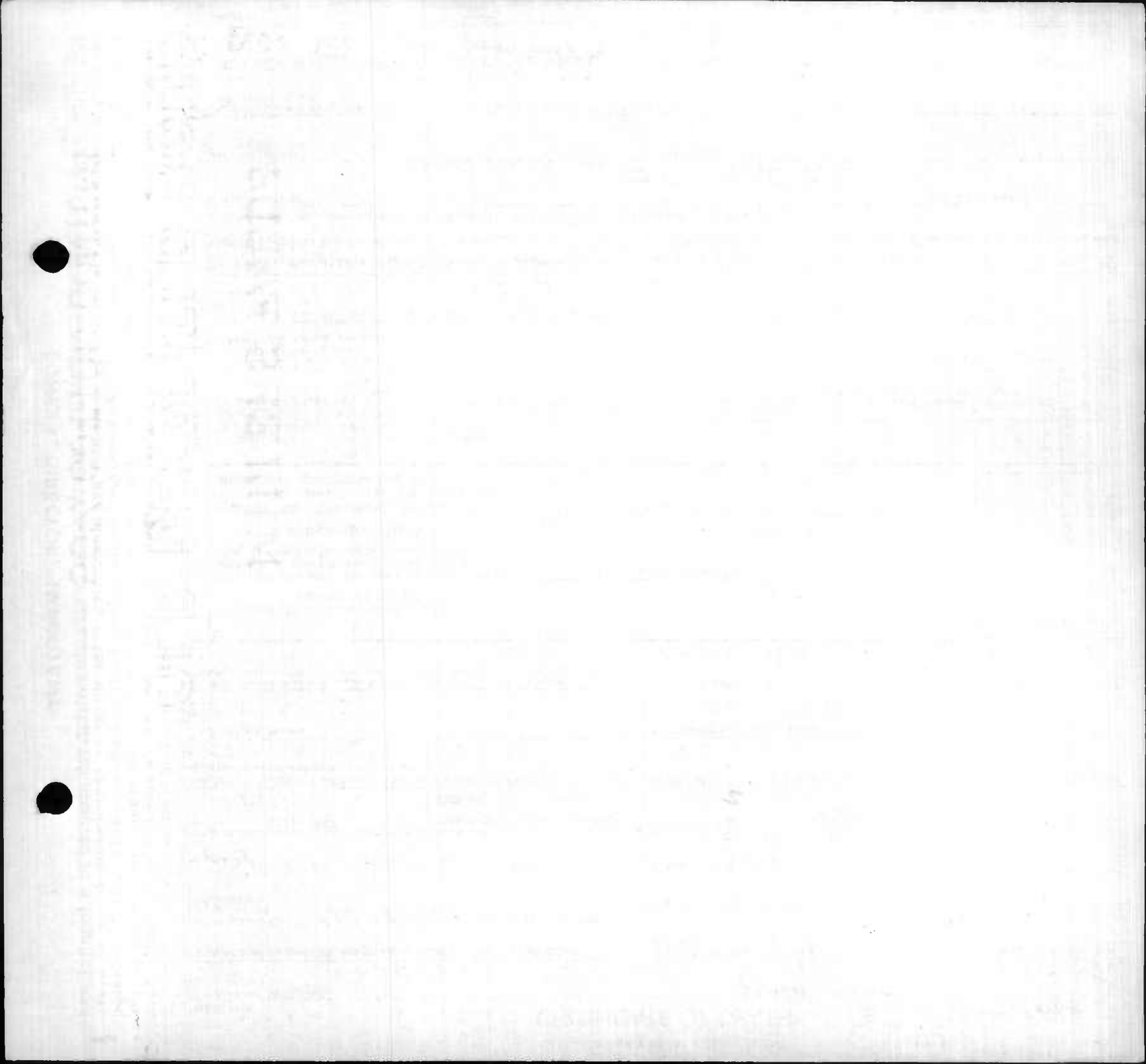
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.2em;">72 11503</span>	
CERTIFICATE OF DEATH					
<b>BIRTH NO.</b> <span style="font-size: 1.2em;">K-530</span>		<b>72 11503</b>			
<b>1. NAME OF DECEASED</b> <small>(Type or Print)</small> <b>CHARLES EDWARD KENT</b>			<b>2. DATE AND HOUR OF DEATH</b> <b>12-2-72</b> <span style="float: right;">11:30 P.M.</span>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> <span style="margin-left: 20px;"><small>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</small></span> <span style="font-size: 1.2em;">LUTHERAN HOSPITAL</span>			<b>4. USUAL RESIDENCE</b> <small>(Where deceased lived. If institution: residence before admission)</small> <b>A. STATE</b> <span style="margin-left: 20px;"><b>B. COUNTY</b></span> <b>MARYLAND</b> <span style="float: right;"><span style="font-size: 1.2em;">1607</span></span> <b>C. CITY OR TOWN</b> <span style="margin-left: 20px;"><b>D. INSIDE CITY LIMITS?</b></span> <b>BALTIMORE</b> <span style="margin-left: 20px;">YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></span> <b>E. STREET AND NUMBER</b> <span style="font-size: 1.2em;">2907 RIGGS AVE</span>		
<b>5. SEX</b> <b>MALE</b>	<b>6. RACE</b> <b>NEGRO</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>12-4-02</b>	<b>9. AGE</b> <small>(In years last birthday)</small> <b>69</b>	<b>10. Under 1 Yr.</b> <input type="checkbox"/> <b>Months</b> <input type="checkbox"/> <b>Days</b> <input type="checkbox"/> <b>Hours</b> <input type="checkbox"/> <b>Min.</b> <input type="checkbox"/>
<b>10A. USUAL OCCUPATION</b> <small>(Give kind of work done during most of working life, even if retired)</small> <b>LABORER</b>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>Consolidated Cons</b>		<b>11. BIRTHPLACE</b> <small>(State or foreign country)</small> <b>Maryland</b>	
<b>13. FATHER'S NAME</b> <b>Thomas Levi Kent</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Rosie Thomas</b>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> <small>(Yes, no or unknown) (If yes, give war or dates of service)</small> <b>NO</b>		<b>16. SOCIAL SECURITY NO.</b> <b>213 03 8464</b>		<b>17. INFORMANT</b> <span style="margin-left: 20px;"><b>ADDRESS</b></span> <b>Charles E. Kent Jr</b> <span style="margin-left: 20px;"><b>Box 112</b></span> <span style="margin-left: 20px;"><b>Owings Mills, Md.</b></span>	
<b>18. CAUSE OF DEATH</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> <small>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</small> <b>ANTECEDENT CAUSES</b> <b>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</b>			<b>(A) IMMEDIATE CAUSE</b> <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <span style="font-size: 1.2em;">CARDIO RESPIRATORY ARREST</span> <b>(B) NO MYO CARDIAL INFARCTION</b> <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <span style="font-size: 1.2em;">NO EMBOLISM, HEMORRHAGE</span>		
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>					
<b>19A. DATE OF OPERATION</b> <b>0</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> <small>(Yes or No)</small> <b>NO</b>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> <small>(notify medical examiner)</small>		<b>21B. PLACE OF INJURY</b> <small>(e.g., in or about home, farm, factory, street, public bldg., etc.)</small>		<b>21C. WHERE DID INJURY OCCUR?</b> <small>(If in Baltimore City, give exact location)</small>	
<b>21D. TIME OF INJURY</b> <small>(Month) (Day) (Year) (Hour)</small> <b>(APPROX.)</b>		<b>21E. INJURY OCCURRED</b> <b>While At Work</b> <input type="checkbox"/> <b>Not While At Work</b> <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from <u>11-29-72</u> to <u>12-2-72</u> that (I) (we) last saw the deceased alive on <u>12-2-72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.2em;">Ruben Manriquez M.D.</span>			<b>Attending Phys.</b> <input type="checkbox"/> <b>Med. Director</b> <input type="checkbox"/> <b>Staff Phys.</b> <input checked="" type="checkbox"/>		<b>23B. DATE SIGNED</b> <b>12-3-72</b>
<b>23C. PHYSICIAN'S NAME</b> <small>(Type)</small> <b>RUBEN MANRIQUEZ MD</b>			<b>23D. ADDRESS</b> <b>LUTHERAN HOSPITAL BALTO, MD</b>		
<b>24A. BURIAL CREMATION, REMOVAL</b> <small>(Specify)</small> <b>Burial</b>		<b>24B. DATE</b> <b>12/6/72</b>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <b>John Wesley</b>	
<b>24D. LOCATION</b> <small>(City, town, or county)</small> <b>Annapolis, Maryland</b>		<b>24E. ADDRESS</b> <small>(City, town, or county)</small> <b>Herbert D. Gutter 3035 W. North Ave</b>			
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>DEC 5 1972</b>		<b>25B. NAME OF REGISTRAR</b> <b>Herbert D. Gutter</b>		<b>25C. FUNERAL DIRECTOR</b> <b>Herbert D. Gutter</b>	



# FUNERAL DIRECTOR: IMPORTANT

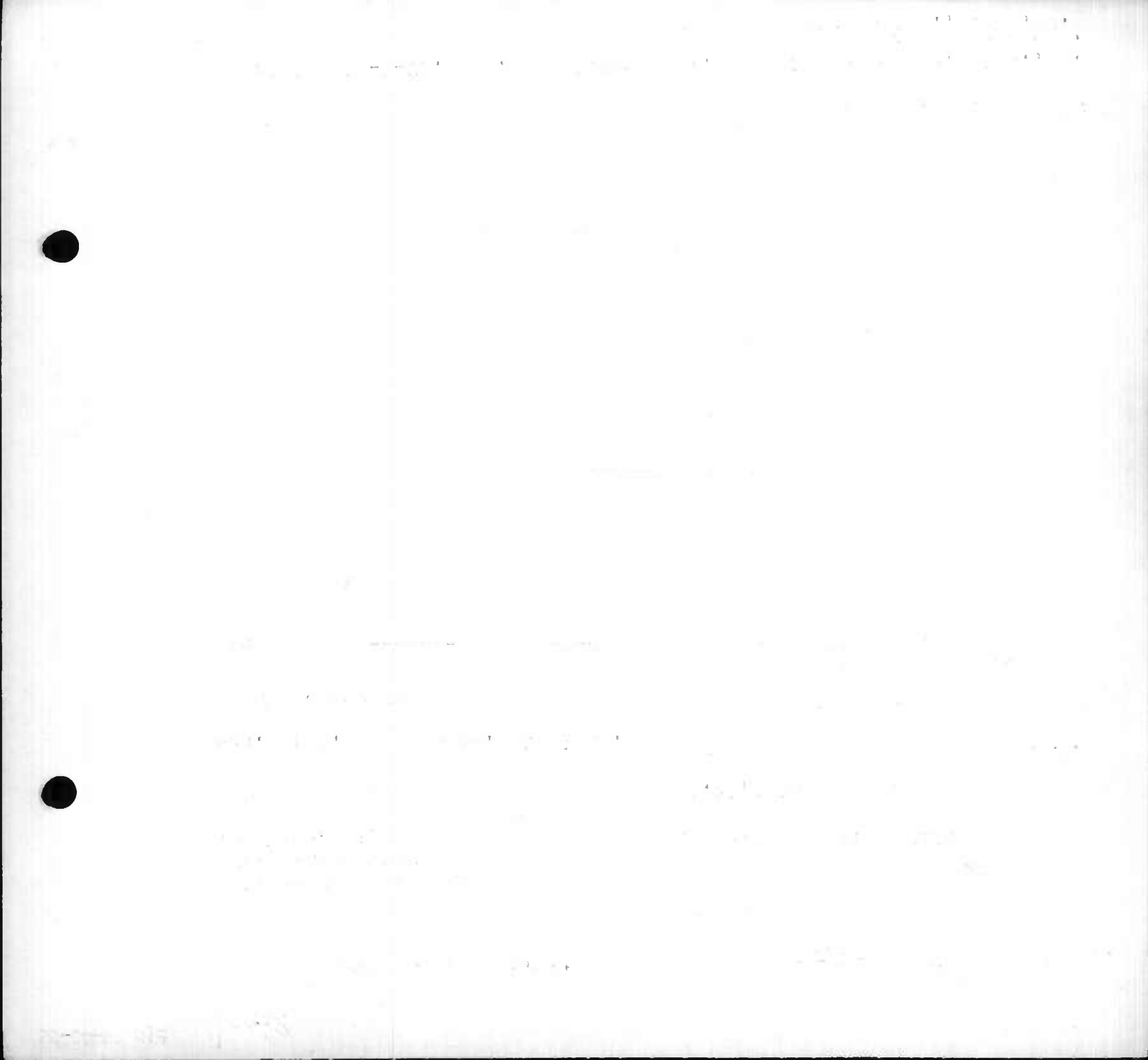
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 11504	
BIRTH NO. 72 11504				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>RIDGLEY, CLARENCE</b>			2. DATE AND HOUR OF DEATH <b>12/1/72 12:25 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>Baltimore</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>MARYLAND GENERAL</b>			C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <b>M</b> 6. RACE <b>C</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>4/2/03</b> 9. AGE (In years last birthday) <b>69</b>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FREIGHT HANDLER</b>			11. BIRTHPLACE (State or foreign country) <b>Md.</b>		
10B. KIND OF BUSINESS OR INDUSTRY <b>B &amp; O RR</b>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>FRANK RIDGLEY</b>			14. MOTHER'S MAIDEN NAME <b>MATHILDA BRYANT</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>A 217-01-8143</b>		
17. INFORMANT			ADDRESS <b>Octavia Ridgley 603 Pitcher Street</b>		
18. <b>15411</b>			CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>CA of return e</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 months</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>metastases</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, home, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED		
21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>12/1/72</b> to <b>12/1/72</b> that (I) (we) last saw the deceased alive on <b>12/1/72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Rabinovitch</b>			23B. DATE SIGNED <b>12/1/72</b>		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE		
24C. NAME of CEMETERY or CREMATORY			24D. LOCATION (City, town, or county) (State)		
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 5 1972</b>			25B. NAME OF REGISTRAR <b>Herbert E. Nutter</b>		
25C. FUNERAL DIRECTOR			ADDRESS <b>3035 W. North Ave</b>		



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-162		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 11505	
BIRTH NO. 72 11505		CERTIFICATE OF DEATH		STATE OF MARYLAND-DHMH	
1. NAME OF DECEASED (Type or Print) <b>James B. Javorski, Sr.</b>		2. DATE AND HOUR OF DEATH <b>12/4/72 7:15</b>		A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2605</b>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Male</b>		6. RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>Oct. 25, 1914</b>		9. AGE (In years last birthday) <b>58</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mech. Dept.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Beth. Steel Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Ludwig Javorski</b>		14. MOTHER'S MAIDEN NAME <b>Antoinette Blazewitz</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-10-1775</b>		17. INFORMANT <b>4940 Eastern Avenue</b> <b>BCH: RECORDS Baltimore, Maryland 21224</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>5-67.01 + 189.0</b> <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <b>Sepsis</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Malignancy</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Subphrenic abscess</b> <b>Ca of Kidney</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 Days</b>		19. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Ca of Kidney</b>			
19A. DATE OF OPERATION <b>3/1/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Sepsis</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>No</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <b>11/28/72</b> 19 to <b>12/4/72</b> 19 that (I) (we) last saw the deceased alive on <b>12/4/72</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Michael J. Zimmer M.D.</b>		23B. DATE SIGNED <b>12/4/72</b>		23C. PHYSICIAN'S NAME (Type) <b>Michael J. Zimmer</b>	
23D. ADDRESS <b>4940 Eastern Avenue BCH Baltimore, Maryland 21224</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-7-72</b>	
24C. NAME of CEMETERY or CREMATORY <b>St. Stanislaus Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>6515 Boston Av. Balto., Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 5 1972</b>	
25B. NAME OF REGISTRAR <b>Audrey H. Hooton</b>		25C. FUNERAL DIRECTOR <b>Charles J. Zailer</b>		25D. ADDRESS <b>6224 Eastern Ave. Balto., 21224, Md.</b>	

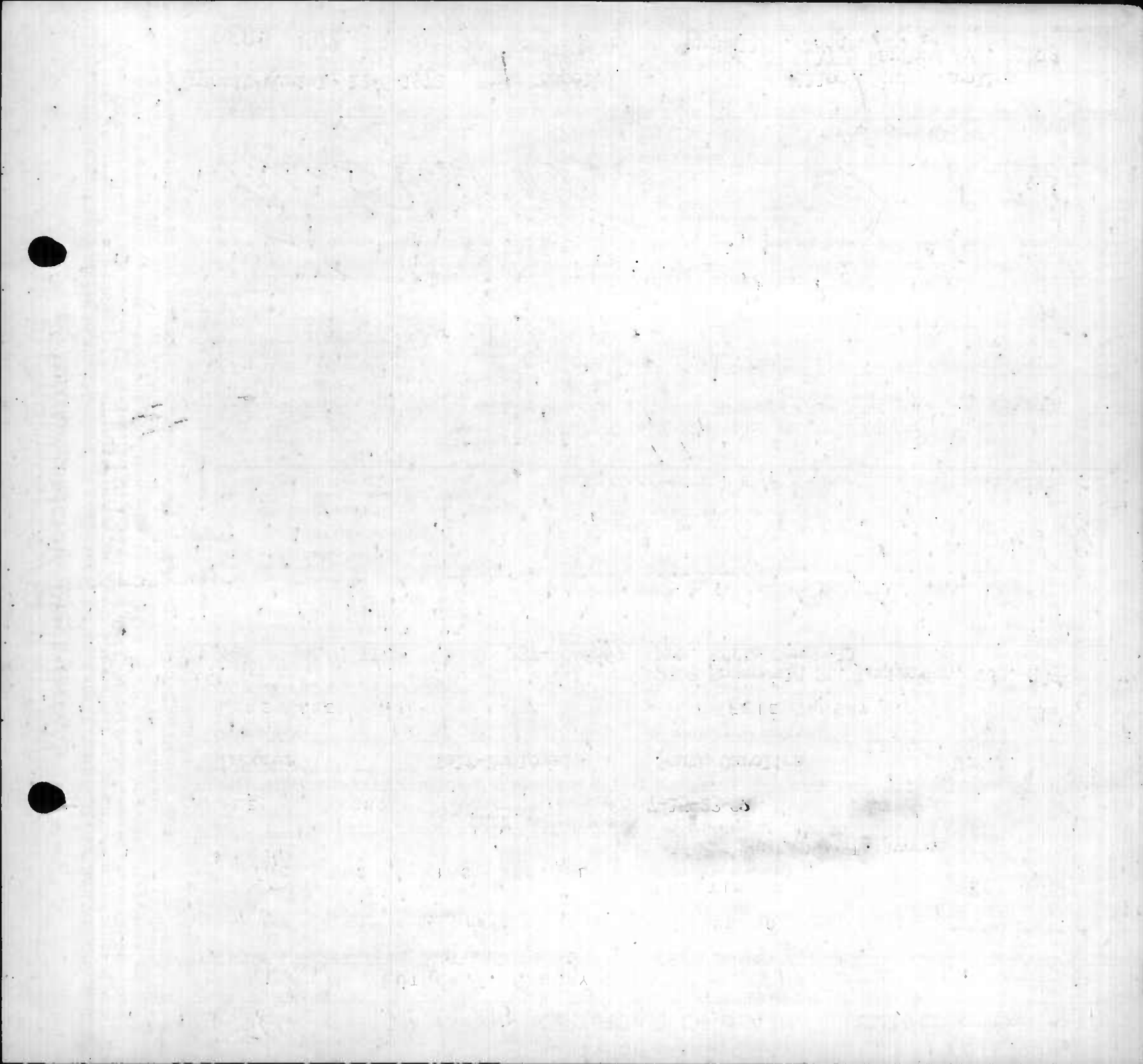




# FUNERAL DIRECTOR: IMPORTANT

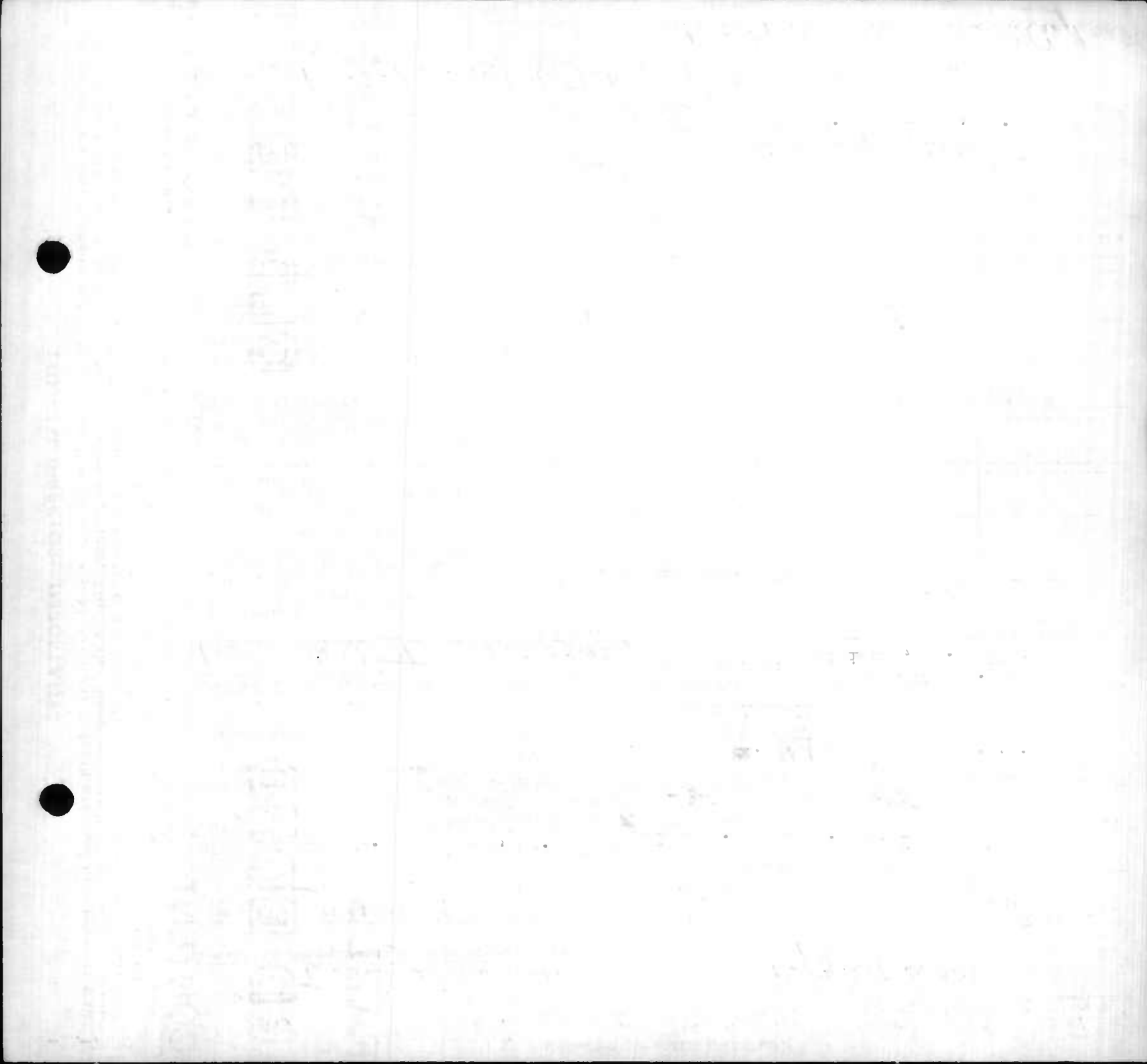
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-560		72 11506		BALTIMORE CITY HEALTH DEPARTMENT		72 11506	
BIRTH NO.		NAME OF DECEASED		DATE AND HOUR OF DEATH		STATE OF MARYLAND - DEATH	
(REV.)		LUTHER T. CANERY		11/30/72		404 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
33 THE JOHNS HOPKINS HOSPITAL				MARYLAND		806	
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				1608 East Lafayette Avenue			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days	11. If Under 24 Hrs. Hours Min.	
MALE	NEGRO	Separated WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7-15-23-77	49			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Laborer		Self-Employed		South Carolina		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
LUKE PAGE				EFFIE CANERY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
yes		W.W. II		237-20-6869		2303 Rosenwald St. Lumberton, N.C. 28358	
				Mrs. Effie Campbell			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)							
ANTECEDENT CAUSES							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				Hypertension, Cerebellar Hemorrhage, Bleeding Ulcers			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
11/16, 11/24, 11/28		Cerebellar Hemorrhage, GI Bleed, Incontinence		NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
No							
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (1) (this hospital) attended the deceased from 11/17/72 1972 to 11/30 1972, that (1) (we) lost saw the deceased alive on 11/30 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Bruce G. Farrell, M.D.				11/30/72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Bruce G. Farrell				Johns Hopkins Hosp - Dept Surgery			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Transit-burial		12-6-1972		Fork Chapel,		Dillon, South Carolina	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
DEC 5 1972		Sidney Johnson		Marshall W. Jones, Jr.		1735 Harford Ave. 21213	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-520		72 11507		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 11507	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Towns, William F.</i>				2. DATE AND HOUR OF DEATH <i>12/3/72 7:20 AM</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>31 Baltimore City Hosp.</i>				A. STATE <i>Maryland</i>			
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <i>4940 Eastern Ave. Baltimore, Md. 21224</i>				B. COUNTY <i>808</i>			
				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>1712 E. Eager St. 21205 007</i>			
5. SEX <i>Male</i>	6. RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>7-23-17</i>	9. AGE (in years last birthday) <i>55</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		
10A. USUAL OCCUPATION		10B. KIND OF BUSINESS OR INDUSTRY <i>employee in S. office</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Judge Towns</i>				14. MOTHER'S MAIDEN NAME <i>Thelma Mitchell</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes W.W. II.</i>				16. SOCIAL SECURITY NO. <i>220-03-4926</i>		17. INFORMANT BCH Records: <i>4940 Eastern Ave. ADDRESS Baltimore, Md. 21224</i>	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <i>Intra cerebral bleed</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Acute Leukemia</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Sepsis</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>11/18</i> 19 <i>72</i> to <i>12/3</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>12/3</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Raman Qazi</i>				23B. DATE SIGNED <i>12/3</i>			
23C. PHYSICIAN'S NAME (Type) <i>Raman Qazi</i>				23D. ADDRESS <i>Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md. 21224</i>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>12-7-72</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Md. Natl. Mem. Park Laurel, Md.</i>		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 5 1972</i>		25B. NAME OF REGISTRAR <i>Disney Johnson</i>		25C. FUNERAL DIRECTOR <i>Funeral Home 1129 N. Caroline St.</i>		ADDRESS	

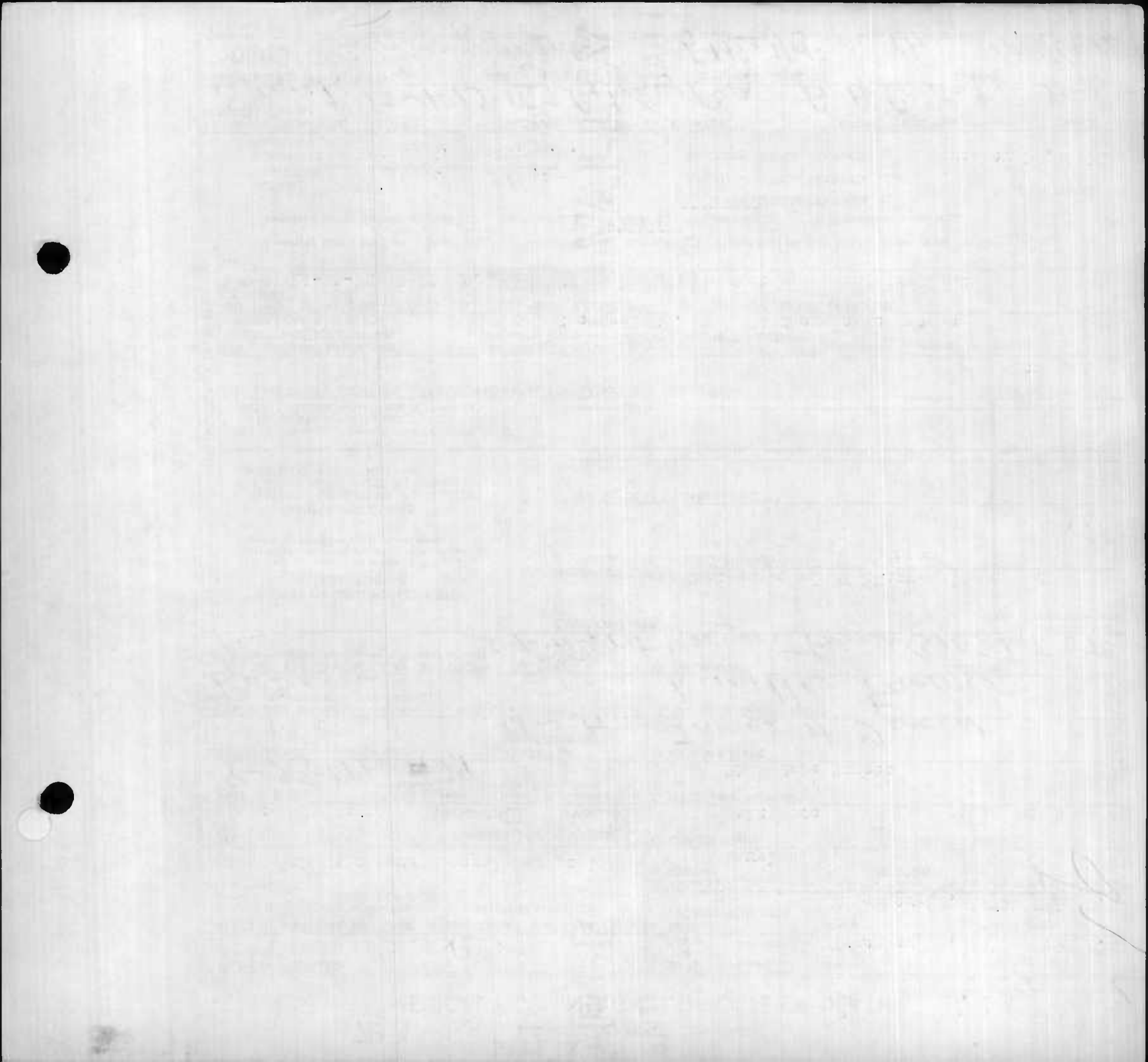


## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 11508

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>STEVEN N. QUEEN</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>November 29, 1972</b> Hour <b>7:55 P.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>South Baltimore General Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>November 29, 1972 7:55 P.M.</b>	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>8-23-44</b>		10. AGE (in years last birthday) <b>28</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James H. Queen</b>		14. MOTHER'S MAIDEN NAME <b>Lucille Farmer</b>	
15. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2506</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b>	
17. SOCIAL SECURITY NO. <b>218-40-8495</b>		18. INFORMANT <b>Margaret Brown</b>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>12-4-72</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>Yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>M &amp; T Chemical Co.</b>	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? <b>1900 Chesapeake Avenue</b>		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>11-29-72 7:21 P.M.</b>	
22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Shot by known assailant</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Marvin S. Platt</b> M.D. EXAMINER'S NAME (Type) <b>Marvin S. Platt, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>November 30, 1972</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-4-72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>M T Ciliary Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>A. A. County Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 5 1972</b>		25B. NAME OF REGISTRAR <b>Sidney [illegible]</b>	
25C. FUNERAL DIRECTOR <b>E. H. [illegible]</b>		ADDRESS <b>129 N. [illegible]</b>	

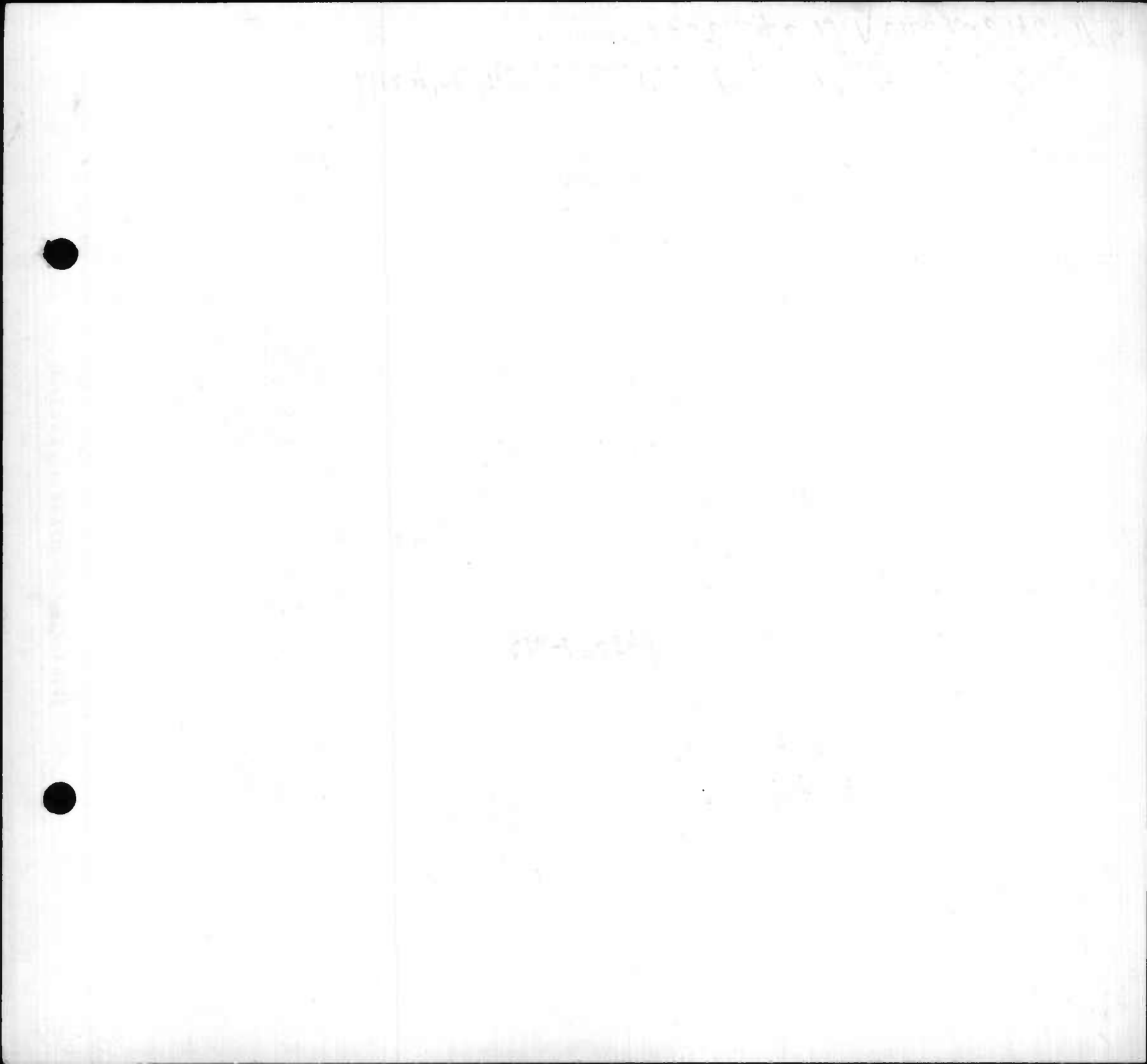




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 72 11509 CERTIFICATE OF DEATH				REG. NO. 72 11509 STATE OF MARYLAND-DMH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Joseph Mc Coy		12/2/72 9:15 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
Lutheran Hospital.				A. STATE Maryland B. COUNTY 1501	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN B. INSIDE CITY LIMITS?	
				BALTIMORE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER	
				2112 Pennsylvania Ave.	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
male	Negro		Sept 20/1904	68 yrs	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Laborer		none		New Kent, Virginia	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
SAMUEL Mc Coy			MARIA Becan		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		216-0542745		David Mc Coy.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cancer of the right kidney, with (B) DUE TO, OR AS A CONSEQUENCE OF: metastasis to the (C) Liver - Hepatic Coma.	
18. 187.01				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
11/21/72		EXPLORATORY Laparotomy		No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/7 1972 to 12/2 1972 that (I) (we) last saw the deceased alive on 12/2/72 1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Renato A. Labog M.D.				12/2/72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
RENATO A. LABOG, M.D.				Lutheran Hospital.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Dec 4/72		12/4/72		Mt Carmel Cemetery	
				Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
DEC 5 1972		Audrey H. Heston		615 E. B. Ruggold 1463 N. Carey	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-140		72 11510		BALTIMORE CITY HEALTH DEPARTMENT		72 11510	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) SEIBEL, GEORGE LOUIS				2. DATE AND HOUR OF DEATH NOVEMBER 29, 1972 10:00 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST AGNES HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4921 LEEDS AVENUE 21227			
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/4/07	9. AGE (In years last birthday) 65	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GALVANIZER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN SEIBEL				14. MOTHER'S MAIDEN NAME KATIE (SOWERS)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. HA 214 01 4872		17. INFORMANT AVE BALTIMORE, MARYLAND 21229 ST AGNES HOSPITAL CATON & WILKENS			
18. 4369 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osihenio, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Cerebral Vascular Accident. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) Generalized Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF: (C) Diffuse Encephalopathy				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <u>(X) (this hospital)</u> attended the deceased from <u>NOVEMBER 26</u> 19 <u>72</u> to <u>NOVEMBER 29</u> 19 <u>72</u> , that <u>(X) (we)</u> last saw the deceased alive on <u>NOVEMBER 29</u> 19 <u>72</u> and that <u>XXX (our)</u> opinion death occurred on the date and hour and from the causes stated above. <u>(X) (we)</u> <u>(did)</u> <u>(did not)</u> view the body after death.							
23A. SIGNATURE <u>San Pedro</u>				23B. DATE SIGNED 11/29/72		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) S. SAN PEDRO, M.D.				23D. ADDRESS BALTIMORE MARYLAND 21229 ST AGNES HOSPITAL CATON & WILKENS AVE			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-2-72		24C. NAME OF CEMETERY or CREMATORY LOUDON PARK CEMETERY		24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. DEC 5 1972		25B. NAME OF REGISTRAR <u>Anthony Wilkens</u>		25C. FUNERAL DIRECTOR HUBBARD FUNERAL HOME		ADDRESS 4107 WILKENS AVE.	

11 OCT 1964

UNIT 10-1-1 100-1-1-1 100-1-1-1 100-1-1-1

21 VONES HOSBLYT CALON 2 HIGHS 2 WAS  
BUTLINOSE 10/10/64 31/10/64

XXXX  
10/10/64 31/10/64

NO

NO 21 VONES HOSBLYT CALON 2 HIGHS 2 WAS  
BUTLINOSE 10/10/64 31/10/64

10/10/64 31/10/64

10/10/64 31/10/64

10/10/64 31/10/64

21 VONES HOSBLYT CALON 2 HIGHS 2 WAS  
BUTLINOSE 10/10/64 31/10/64

10/10/64 31/10/64

10/10/64 31/10/64

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

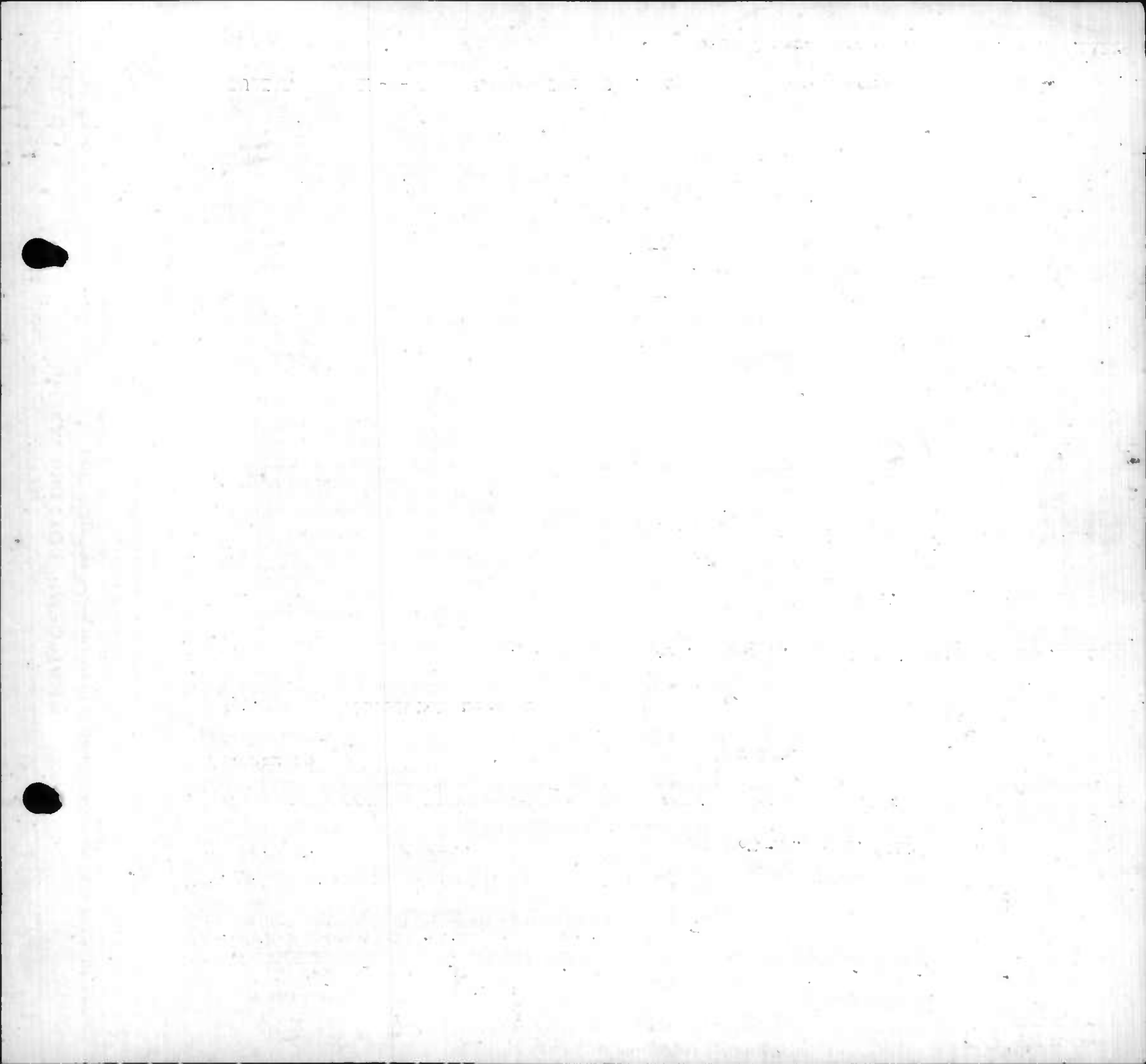
BALTIMORE CITY HEALTH DEPARTMENT				72 11511		REG. NO. 72 11511	
<div style="display: flex; justify-content: space-between;"> <span>M-540</span> <span>72 11511</span> <span>CERTIFICATE OF DEATH</span> </div>							
1. NAME OF DECEASED (Type or Print) <u>JOHN H. MANLEY SR.</u>				2. DATE AND HOUR OF DEATH <u>11-30-72</u> <u>1:35</u> A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>UNIVERSITY OF MD. HOSPITAL 12-11-72</u> <u>38</u>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>2551</u>			
				C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>3583 Benzinger Rd</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-13-08</u>	9. AGE (In years last birthday) <u>64</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>P&amp;G</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>	
13. FATHER'S NAME <u>William Manley</u>				14. MOTHER'S MAIDEN NAME <u>Ethel Keyes</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>10-31-25 to 8-9-29</u>		16. SOCIAL SECURITY NO. <u>217-01-8469</u>		17. INFORMANT <u>Mrs. Mildred E. Manley 3583 Benzinger Rd.</u>			
18. <u>450X1</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Pulmonary Embolus</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>	
				(B) <u>COPD</u> DUE TO, OR AS A CONSEQUENCE OF:			
				(C) _____			
<div style="text-align: center;">II</div> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>COPD</u>							
19A. DATE OF OPERATION <u>11-30-72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>11-21</u> 19 <u>72</u> to <u>11-30</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>11-30</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>William E. Randall Jr MD</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>11-30-72</u>	
23C. PHYSICIAN'S NAME (Type) <u>William E. Randall, Jr.</u>				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>12-4-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Crest Lawn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Howard County</u> <u>Anne Arundel Co. Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 5 1972</u>		25B. NAME OF REGISTRAR <u>Sidney H. Heston</u>		25C. FUNERAL DIRECTOR <u>Hubbard Funeral Home 4107 Wilkens Ave.</u>			

12-11-1972 -Letter and correction form from the Funeral Director, Howard H. Hubbard Funeral Home, Inc., Balto., Md. signed by Robert E. Ramsey - HRS

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT						REG. NO. <u>72 11512</u>
<u>W-452</u> <u>72 11512</u> <b>CERTIFICATE OF DEATH</b> <u>X</u> <u>STATE OF MARYLAND-DEPT</u>						
BIRTH NO. <u>72 11512</u>		1. NAME OF DECEASED (Type or Print) <u>Williams, Hilda V.</u>				
2. DATE AND HOUR OF DEATH <u>2:10 P.M.</u> <u>11-30-72</u> M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Canton Manor Nursing Home</u>				
FULL NAME OF HOSPITAL OR INSTITUTION <u>3500 Wilkens Avenue</u> <u>Baltimore MD</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>BALTO</u> <u>5380</u>		
C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
E. STREET AND NUMBER <u>3683 McTavish Ave. 21229</u>						
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-18-1906</u> <u>66</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday)		
13. FATHER'S NAME <u>William <del>XXXXXX</del> Creager</u>		14. MOTHER'S MAIDEN NAME <u>mitte Price</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-16-6912</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
18. <u>734.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Housewife</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Systemic lupus Erythematosus 4 yrs</u> (B) <u>Multifactorial Embolization 4 mos.</u> (C) _____				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>						
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). _____						
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) _____		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>19 1968</u> to <u>Nov 30 19 72</u> that (I) ( <del>we</del> ) last saw the deceased alive on <u>11/30/72</u> 19 _____ and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.						
23A. SIGNATURE <u>Paul Passmore</u> DEGREE _____				23B. DATE SIGNED <u>11/30/72</u>		
23C. PHYSICIAN'S NAME (Type) <u>Encl Pass</u> DEGREE _____				23D. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>12-4-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		
24D. LOCATION (City, town, or county) (State) <u>Baltimore</u> <u>Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 5 1972</u>				
25B. NAME OF REGISTRAR <u>Sidney Wharton</u>		25C. FUNERAL DIRECTOR <u>Hubbard Funeral Home</u> <u>4107 Wilkens Ave. 21229</u>				



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Last, or Print) <i>Phoebe Helen Maisel</i>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 11 30 72 5:18 P. M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>40 St. Agnes Hospital</i>				3. DATE PRONOUNCED DEAD Month Day Year Hour 11 30 72 5:18 P. M.			
6. SEX Female				7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 3-20-1904				10. AGE (in years last birthday) 68		11. BIRTHPLACE (State or foreign country) Westminster, Md. County	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Edward F. Jackson			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				14B. KIND OF BUSINESS OR INDUSTRY HOME			
15. MOTHER'S MAIDEN NAME Mary R. Everhart				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO			
17. SOCIAL SECURITY NO.				18. INFORMANT Daisy G. Scaggs			
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				22D. TIME OF INJURY (APPROX.)			
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) William P. Mulloy, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
DATE SIGNED 12-1-72							
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				24B. DATE 12/3/72			
24C. NAME OF CEMETERY or CREMATORY EMMANUEL CEM.				24D. LOCATION (City, town, or county) (State) SCAGGSVILLE, MD			
25A. DATE REC'D BY HEALTH DEPT DEC 5 1972				25B. NAME OF REGISTRAR Sidney Johnson			
25C. FUNERAL DIRECTOR Donald H. Funeral Home				ADDRESS Laurel			







# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 11514		STATE OF MARYLAND - DEPT	
S-200		72 11514		REG. NO. 72 11514	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		SIX, JOHN A		DECEMBER 1, 1972 9:30A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY		6300	
FULL NAME OF HOSPITAL OR INSTITUTION  40 ST. AGNES HOSPITAL		MARYLAND HOWARD			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN JESSUP		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER 10519 GUILFORD RD 20794			
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 09/18/99	9. AGE (In years last birthday) 73	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CUSTODIAN
		11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME CHARLES SIX		14. MOTHER'S MAIDEN NAME MOLLY HILTNER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates at service) YES W W 1		16. SOCIAL SECURITY NO. 214-28-9788		17. INFORMANT AVE BALTO, MD 21229 ST. AGNES HOSPITAL; CATON & WILKENS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE Coronary artery disease DUE TO, OR AS A CONSEQUENCE OF: (B) old myocardial infarction DUE TO, OR AS A CONSEQUENCE OF: (C) Papillary muscle dysfunction D A S C - V. D		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 21		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from NOVEMBER 28 1972 to DECEMBER 1 1972, that (I) (we) lost saw the deceased alive on DECEMBER 1 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE E. Henzan M.D.				23B. DATE SIGNED 12/1/72	
23C. PHYSICIAN'S NAME (Type) E. HENZAN		23D. ADDRESS BALTO, MD 21229 ST. AGNES HOSPITAL; CATON & WILKENS AVE S			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/4/72		24C. NAME of CEMETERY or CREMATORY Iny Hill Cemetery Laurel Maryland	
24D. LOCATION (City, town, or county) (State)					
25A. DATE REC'D BY HEALTH DEPT. DEC 5 1972		25B. NAME OF REGISTRAR Sidney Johnston		25C. FUNERAL DIRECTOR D. S. Johnson Funeral Home Md.	

IN VENEZUELA  
OFFICE OF THE  
DIRECTOR OF THE  
INVESTIGATION

DECEMBER 1 1958  
NOVEMBER 28 1958  
DECEMBER 1 1958

ALL INFORMATION CONTAINED  
HEREIN IS UNCLASSIFIED  
DATE 11-11-81 BY 1043

ALL INFORMATION CONTAINED  
HEREIN IS UNCLASSIFIED  
DATE 11-11-81 BY 1043

ALL INFORMATION CONTAINED  
HEREIN IS UNCLASSIFIED  
DATE 11-11-81 BY 1043

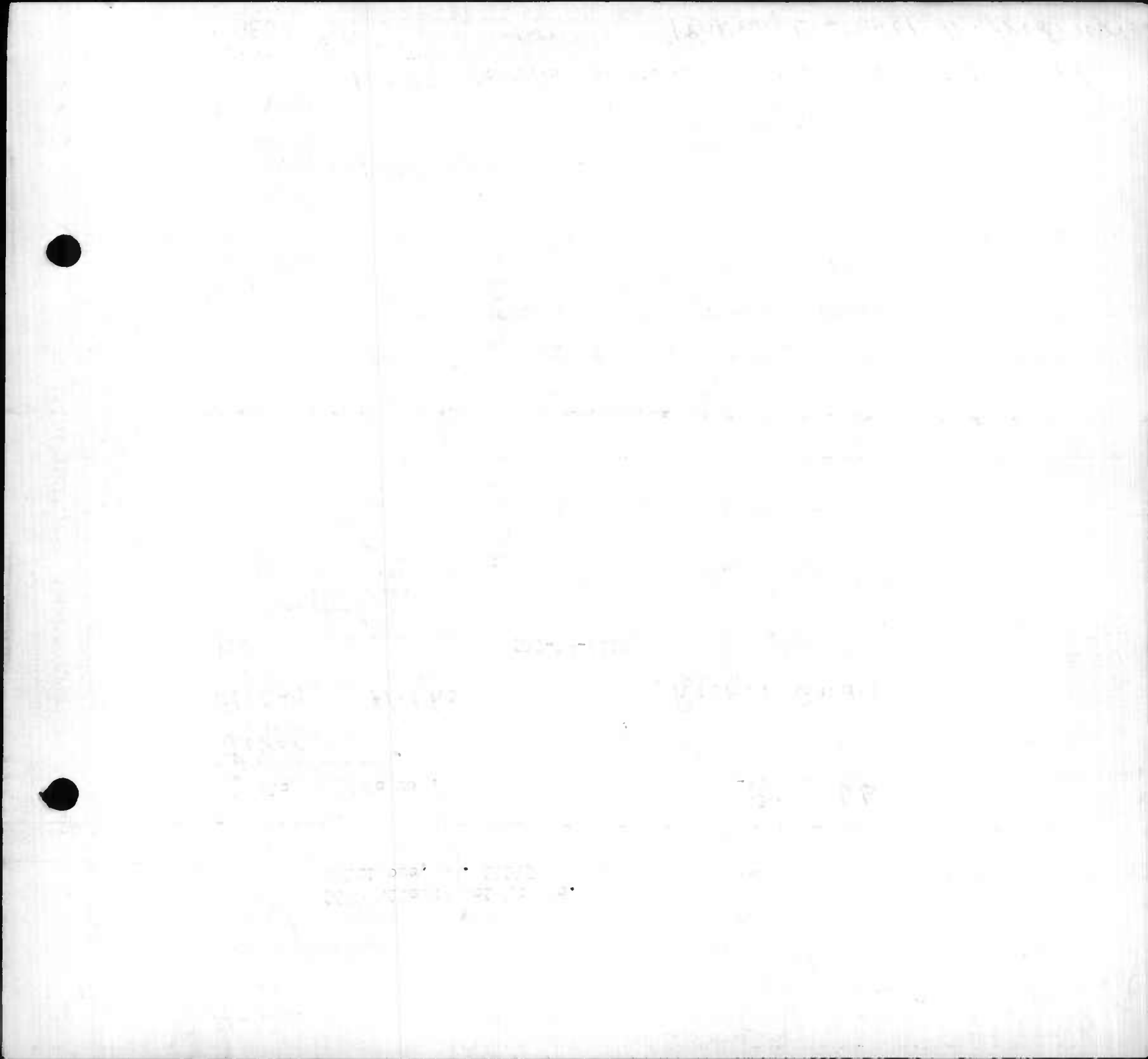
ALL INFORMATION CONTAINED  
HEREIN IS UNCLASSIFIED  
DATE 11-11-81 BY 1043

ALL INFORMATION CONTAINED  
HEREIN IS UNCLASSIFIED  
DATE 11-11-81 BY 1043

# FUNERAL DIRECTOR: IMPORTANT

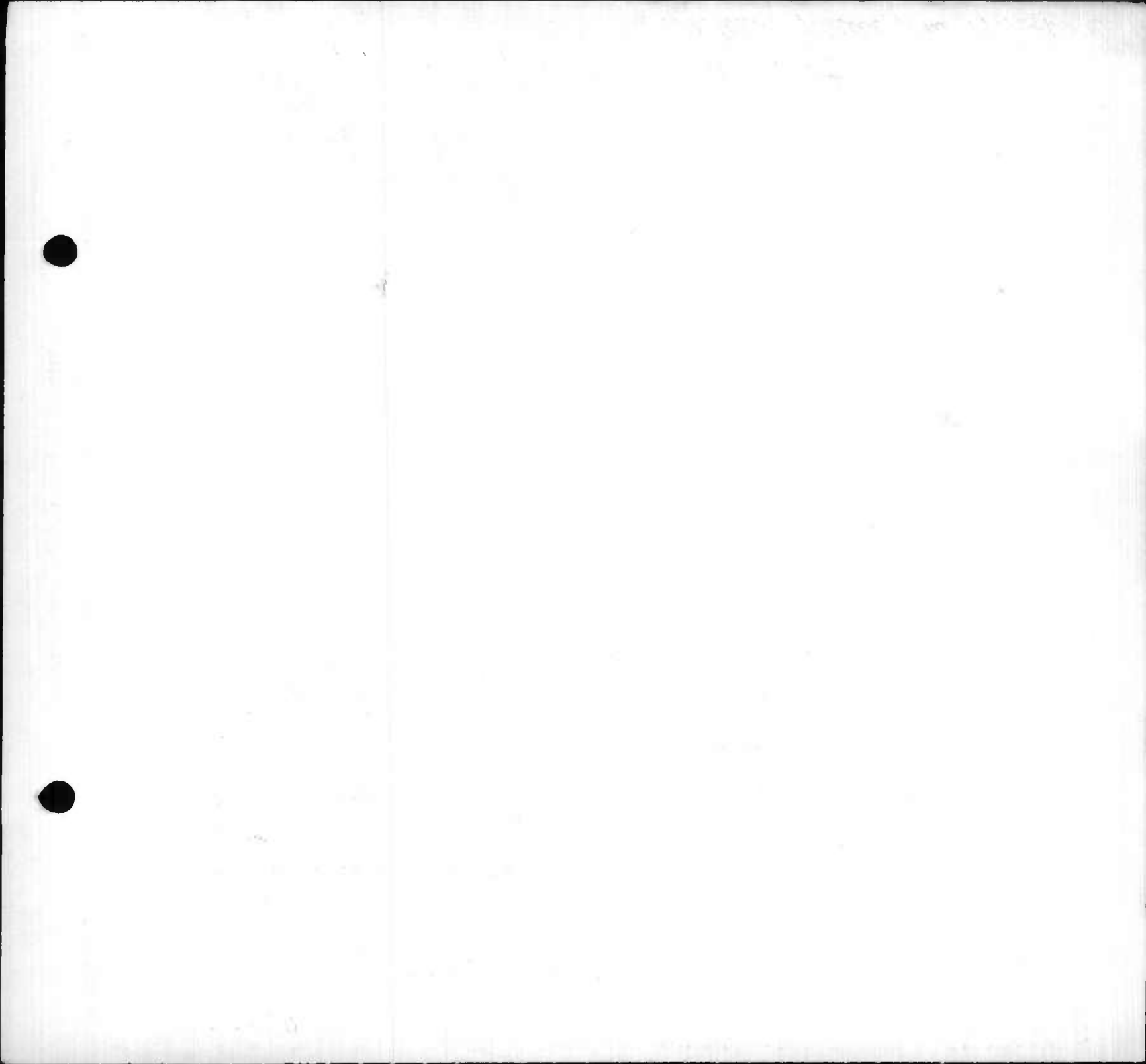
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-200		72 11515		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 11515	
BIRTH NO.				STATE OF MARYLAND DEPT.			
1. NAME OF DECEASED (Type or Print) <i>Lawrence Hicks</i>				2. DATE AND HOUR OF DEATH <i>11/29/72 10:41 P.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>President Hospital Inc.</i>				A. STATE <i>Maryland</i>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>2600 Liberty Height Ave. Baltimore, Md. 21215</i>				B. COUNTY <i>1513</i>			
				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>4001 Ruby Manor Drive</i>			
5. SEX <i>Male</i>	6. RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>08-10-06</i>	9. AGE (In years last birthday) <i>66 yrs.</i>	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Labor</i>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Elizabeth Hicks</i>				14. MOTHER'S MAIDEN NAME <i>Rachel Gardie</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>217-16-6648</i>		17. INFORMANT <i>Mrs. Marylyn Perry (daughter)</i>		ADDRESS <i>4001 Ruby Manor Dr.</i>	
18. <i>579121</i>				CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE <i>Severe Respiratory Acidosis</i> DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <i>Chronic Lung Disease &amp; Conges-</i> DUE TO, OR AS A CONSEQUENCE OF:			
				(C) <i>Left Heart Failure</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>11-28</i> 19 <i>72</i> to <i>11-29-72</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>11-29</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Virginia F. Mercado, M.D.</i>				23B. DATE SIGNED <i>11-29-72</i>		23C. PHYSICIAN'S NAME (Type) <i>VIRGINIA F. MERCADO M.D.</i>	
23D. ADDRESS <i>4001 Ruby Manor President Hospital Inc.</i>				23E. ADDRESS <i>4001 Ruby Manor President Hospital Inc.</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <i>12-3-72</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Carrolls Chr. Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Calvert Co., Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 5 1972</i>		25B. NAME OF REGISTRAR <i>Lindsey Houston</i>		25C. FUNERAL DIRECTOR <i>Pinkey E. Sewell</i>		25D. ADDRESS <i>Pr. Fred. Ind.</i>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 11516		REG. NO. 72 11516	
BIRTH NO. B-650				72 11516		STATE OF MARYLAND-DEM	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
BROWN, LILLIAN R.				DEC-1-1972 10-45 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
38 UNIVERSITY HOSPITAL BALTIMORE				MARYLAND BALTIMORE 1801			
5. SEX F 6. RACE NEGRO 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 3-25-08		9. AGE (In years last birthday) 64	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				11. BIRTHPLACE (State or foreign country) MARYLAND, Balto.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John ?				14. MOTHER'S MAIDEN NAME BERTIE CURTIS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO NO				16. SOCIAL SECURITY NO. 213-36-2402		17. INFORMANT ADDRESS HOLLIE BROWN 728-7046 950 SARACOTA ST.	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: STROKE		6	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(B) DUE TO, OR AS A CONSEQUENCE OF: AORTIC ARCH ANEURYSM		YRS	
(C)							
19A. DATE OF OPERATION 11-25-72 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED AORTIC ANEURYSM				20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11-6-1972 to 12-1-1972 that (I) (we) last saw the deceased alive on 12-1-1972 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE G. J. M. Reddy				23B. DATE SIGNED 12-1-72		23C. PHYSICIAN'S NAME (Type) G. J. M. REDDY	
23D. ADDRESS UNIVERSITY HOSPITAL				23E. DATE 12-1-72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/5/72		24C. NAME of CEMETERY or CREMATORY Mt. Calvary Cem.		24D. LOCATION (City, town, or county) (State) Center Hill Md	
25A. DATE REC'D BY HEALTH DEPT DEC 5 1972		25B. NAME OF REGISTRAR Sidney L. Johnson		25C. FUNERAL DIRECTOR W. L. Harris		25D. ADDRESS 3199 Remondast	



72 11517 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

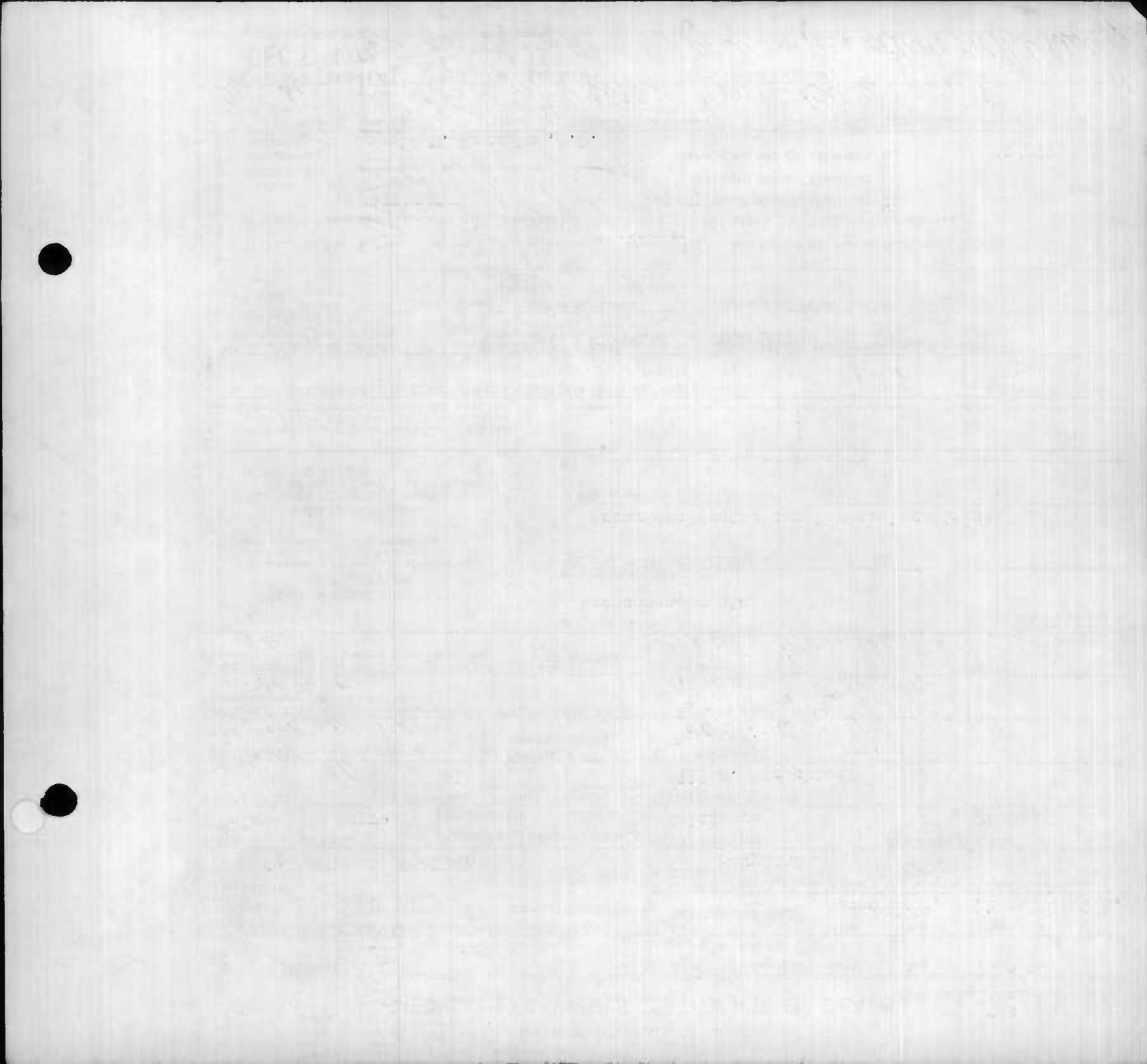
REG. NO.

72 11517

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>ELLSWOTH THOMPSON</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>BON SECOURS HOSPITAL</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>December 2, 1972 10:02 P.M.</b>	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>Oct 1911</b>		10. AGE (In years last birthday) <b>61</b>	
11. BIRTHPLACE (State or foreign country) <b>Churchtown Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Theophilus Thompson</b>		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1803</b>	
15. STREET AND NUMBER <b>117 S. Stockton</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		17. KIND OF BUSINESS OR INDUSTRY	
18. MOTHER'S MAIDEN NAME <b>Alice C. Brown</b>		19. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>	
20. SOCIAL SECURITY NO.		21. INFORMANT <b>Rufus Thompson</b>	
22. ADDRESS <b>907 N. Wheeler Ave.</b>		23. CAUSE OF DEATH <b>Bronchopneumonia</b>	
24. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		25. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Arteriosclerotic cardiovascular disease</b>	
26. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		27. (B) DUE TO, OR AS A CONSEQUENCE OF:	
28. (C)		29. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>yes</b>		22. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22A. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22B. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22C. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22D. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22E. HOW DID INJURY OCCUR?		23.	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER(S) <b>Ronald N. Kornblum, M.D.</b>		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>12/3/72</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	
24B. DATE <b>12/6/1972</b>		24C. NAME of CEMETERY or CREMATORY <b>Wt. Auburn Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 5 1972</b>	
25B. NAME OF REGISTRAR <b>Sidney S. Gordon</b>		25C. FUNERAL DIRECTOR <b>Williams Funeral Home</b>	
ADDRESS <b>319 N. Schroeder</b>			







MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
STATE OF MARYLAND-DEMH

REG. NO. 72 11518

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

OTIS GORDON

2. DATE OF DEATH Known ☒ Estimated ☐ Month Day Year Hour  
December 2, 1972 M.4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  
OR INSTITUTION

SOUTH BALTO. GENERAL HOSPITAL (DOA)

3. DATE PRONOUNCED DEAD Month Day Year Hour  
December 2, 1972 11:37 PM5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE B. COUNTY

Maryland

1701

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐ NO ☐

9. DATE OF BIRTH

5/16/06

10. AGE (in years, last birthday)

66

11. Under 1 Yr. 12 Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

639 W. Franklin Street

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

John Gordon

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Unemployed

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Ida

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

17. SOCIAL SECURITY NO.

578-18-4182

18. INFORMANT

Mr Thomas Campbell, same

ADDRESS 641 W Frankl St

19. E 814.71

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

Multiple Injuries

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  
Street

22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? Harbor Tunnel Thruway 148' N. of O'Donnell Street, entrance

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  
12-2-72 10:55 P.m.22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

22F. HOW DID INJURY OCCUR? (struck by car) Crawling across roadbed

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL SIGNATURE  
EXAMINER'S NAME (Type)

Marvin S. Platt, M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/3/72

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

12/7/72

24C. NAME OF CEMETERY or CREMATORY

Mt Auburn Cemetery

24D. LOCATION (City, town, or county) (State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

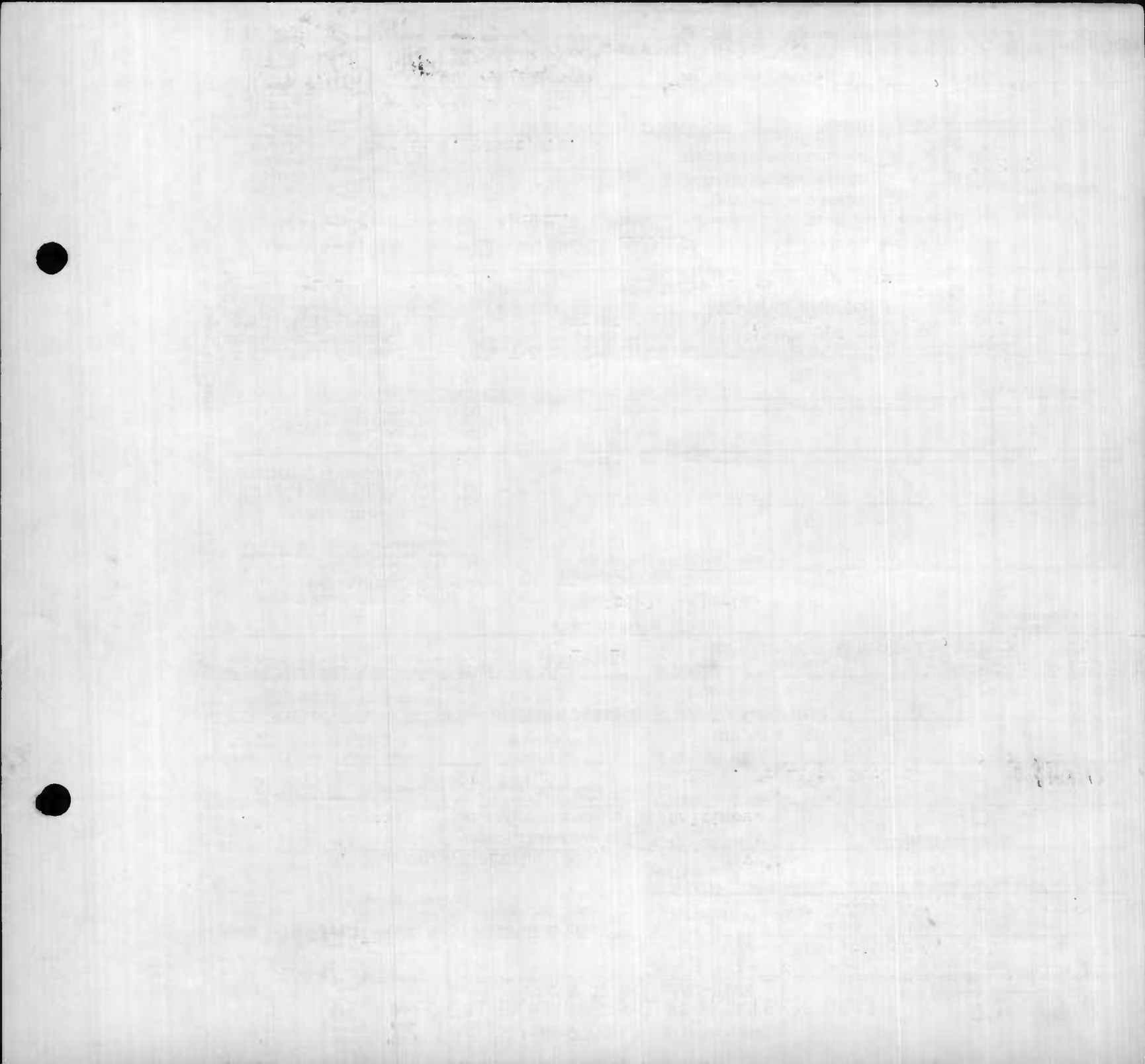
DEC 6 1972

25B. NAME OF REGISTRAR

Sidney H. Weston

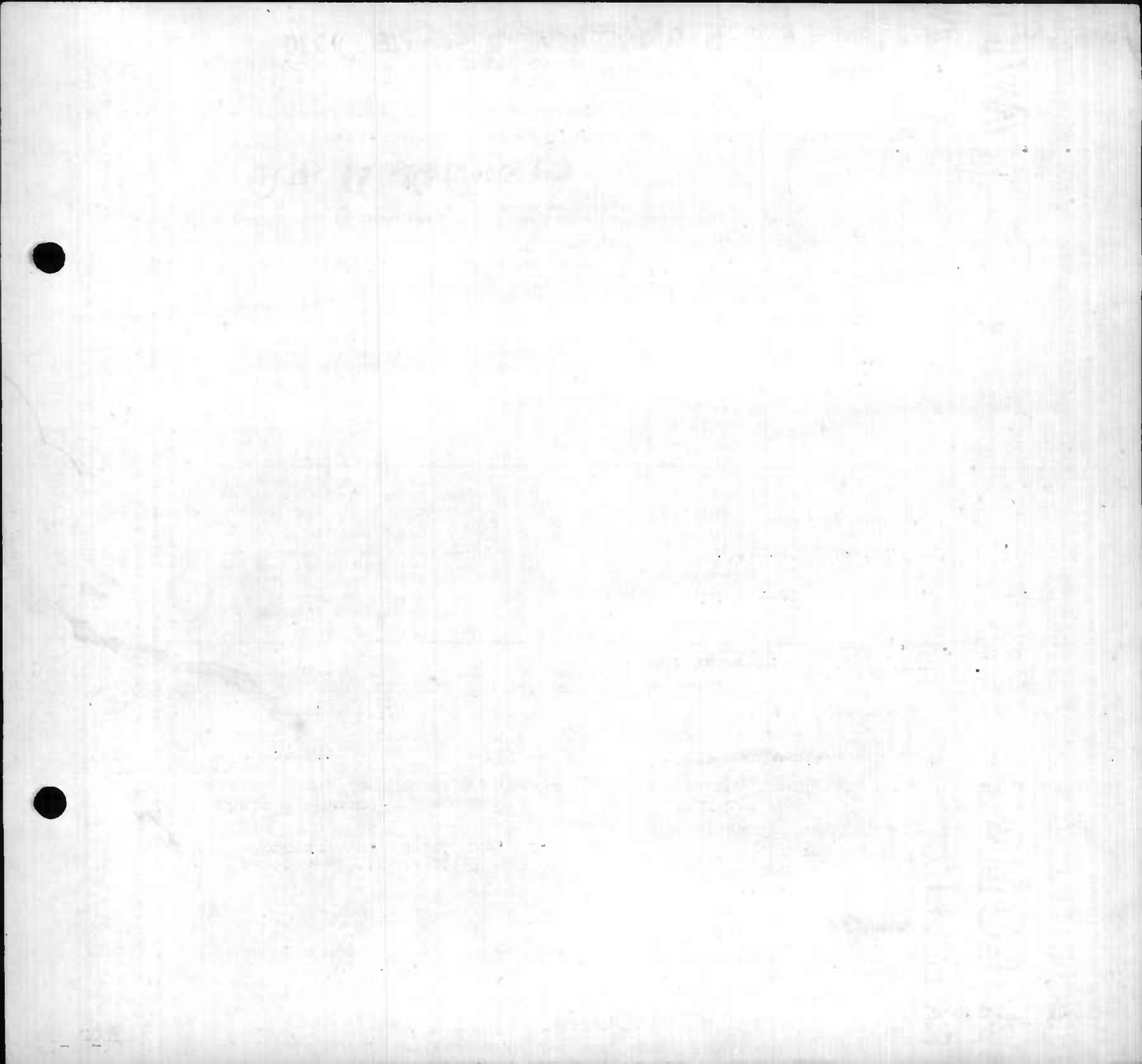
25C. FUNERAL DIRECTOR

Adolphus Halstead 12056 W North Ave



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 11519			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH				STATE OF MARYLAND-DEATH			
Martin, James Linwood				3 December 1972				6:30 a M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				Maryland				907			
Baltimore City Hospital 4940 Eastern Ave. Baltimore, Md. 21224				C. CITY OR TOWN				D. INSIDE CITY LIMITS?			
				Baltimore				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER				2534 Garrett Ave				21218			
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. Under 1 Yr. Months Days	
Male		Negro		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		12-15-21		50			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)			
dry cleaner				self employed				Pennsylvania			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				12. CITIZEN OF WHAT COUNTRY?			
James Martin				Gertrude (deceased)				USA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS			
non								BCH Records: 4940 Eastern Ave. Baltimore, Md. 21224			
18. 400.91				CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE				48hrs			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				DUE TO, OR AS A CONSEQUENCE OF:							
ANTECEDENT CAUSES				Malignant hypertension				1 yr			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:							
				CHF				6 mos			
(C) DUE TO, OR AS A CONSEQUENCE OF:											
II				Renal Failure				6 mos			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).											
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)			
2 none								yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notably medical examined) no				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) no				21C. WHERE DID INJURY OCCUR? no			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) no				21E. INJURY OCCURRED While At Work <input type="checkbox"/> no Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR? no			
22. I certify that (I) (this hospital) attended the deceased from 16 November 1972 to 3 December 1972, that (I) (we) last saw the deceased alive on 2 December 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE				23B. DATE SIGNED							
Peter B. DeOreo, M.D.				12-3-72							
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS							
Peter Bulter DeOreo, M.D.				4940 Eastern Ave. Baltimore, Md. 21224							
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE				24C. NAME OF CEMETERY or CREMATORY			
Burial				12/6/72				M* Auburn Cemetery			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR				25C. FUNERAL DIRECTOR ADDRESS			
DEC 6 1972				Sidney H. [Signature]				6 Adolphus Halstead 1206 W North Ave			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 11520	
72 11520				STATE OF MARYLAND-DMH	
BIRTH NO.				DECEASED	
1. NAME OF DECEASED (Type or Print)		BURKE, LILLIAN REBECCA		2. DATE AND HOUR OF DEATH DECEMBER 3, 1972 12:40P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL			A. STATE MARYLAND B. COUNTY BALTIMORE 21227		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
			E. STREET AND NUMBER 814 SECKEL COURT 5300		
5. SEX FEMALE	6. RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 01 12 11	9. AGE (In years last birthday) 61	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN MORAN		14. MOTHER'S MAIDEN NAME ANNA JONES	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214149344		17. INFORMANT RECORDS OF ST. AGNES HOSPITAL CATON & WILKENS AVES. BALTO., MD. 21229	
18. 174 X I CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: RENAL FAILURE days	
				(B) METASTATIC CARCINOMA months	
				(C) BREAST CARCINOMA yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). LYMPHEDEMA @ ARM.					
19A. DATE OF OPERATION 0 10/25/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Lymphedema of arm		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 10/24/72 to 12/3/72, that (X) (we) last saw the deceased alive on 12/3/72 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE C.R. Chaney M.D.				23B. DATE SIGNED 12/3/72	
23C. PHYSICIAN'S NAME (Type) C.R. CHANEY M.D.				23D. ADDRESS AVES. BALTO., MD. 21229 ST. AGNES HOSPITAL-CATON & WILKENS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-6-72		24C. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery	
24D. LOCATION (City, town, or county) (State) Balto. Maryland		25A. DATE REC'D BY HEALTH DEPT. DEC 6 1972		25B. NAME OF REGISTRAR Sidney [Signature]	
25C. FUNERAL DIRECTOR McGully Funeral Home 130 E. Fort Ave. 21230					





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

REG. NO. 72 11521

## STATE OF MARYLAND-DIVISION OF TAXATION

VS 150-REV. 1/1/6B



10/10/10

3/1/11

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 11522

BIRTH NO.		M.		STATE OF MARYLAND-DRMH		REG. NO. 72 11522	
1. NAME OF DECEASED (Type or Print) NANOMA TABELING				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 48 Maryland General Hospital				3. DATE PRONOUNCED DEAD Month Day Year Hour 12 3 1972 4:30p M.			
6. SEX female				7. RACE white		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH Aug. 22, 1925				10. AGE (in years last birthday) 47		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Gray		14. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission) A. STATE Md. B. COUNTY 401	
15. MOTHER'S MAIDEN NAME Hilsa Rice				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no			
17. SOCIAL SECURITY NO.				18. INFORMANT ADDRESS Mr. John H. Tabeling same			
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E950.3 Cerebral Edema				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Ingestion of UNIDENTIFIED Toxic substance			
(B) DUE TO, OR AS A CONSEQUENCE OF:				(C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
20A. DATE OF OPERATION 2				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home			
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? 311 Cathedral Street 04-01				22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 11-12-72 ? m.			
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				22F. HOW DID INJURY OCCUR? Ingested toxic substance			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell S. Fisher, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 12/4/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 12/4/72			
24C. NAME OF CEMETERY or CREMATORY Parkwood				24D. LOCATION (City, town, or county) (State) Balto. Md.			
25A. DATE REC'D BY HEALTH DEPT. DEC 6 1972				25B. NAME OF REGISTRAR Audrey H. Hooton			
25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md.				ADDRESS			

1-9-1973 - Letter from the Office of the Chief Medical Examiner, Russell S. Fisher, M.D.,  
Chief Medical Examiner. hs

72 11523

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 11523

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)L.  
JOSEPH MUTH2. DATE  
OF  
DEATHKnown ☐  
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR INSTITUTION  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

6. SEX

male

7. RACE

white

8. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

May 4, 1930

10. AGE (in years  
last birthday)

42

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

6108 Macbeth Dr.

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Leo S. Muth

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Private Police

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Rose D. Egan

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

yes Korea

17. SOCIAL  
SECURITY NO.

218-26-5986

18. INFORMANT

ADDRESS

Leo S. Muth 1525 Ramblewood Road

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

Salicylate intoxication

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRI-  
BUTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)

Home

22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

6108 Macbeth Dr.

22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.)

12-3-72

?

m.

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Ingested overdose of drugs

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE

EXAMINER'S

NAME (Type) Russell S. Fisher, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-4-72

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

12/7/72

24C. NAME of CEMETERY or CREMATORY

New Cathedral

24D. LOCATION (City, town, or county)

Balto. Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

DEC 6 1972

25B. NAME OF REGISTRAR

Sidney Indurton

25C. FUNERAL DIRECTOR

Leonard J. Ruck Inc. Balto. Md.

ADDRESS

12-19-1972 - Letter from the Office of the Chief Medical Examiner, Russell S. Fisher, M.D.,  
Chief Medical Examiner

hs

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
72 11524 CERTIFICATE OF DEATH

REG. NO. 72 11524  
STATE OF MARYLAND - DHMH

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		MARIE F. FIELDS		DECEMBER 3 1972 12 <sup>53</sup> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION SOUTH BALTIMORE GENERAL HOSPITAL				A. STATE MARYLAND	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				B. COUNTY	
				C. CITY OR TOWN BALTIMORE	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 912 S. CAREY STREET 21223	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 10-24-98	9. AGE (In years last birthday) 74
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) seamstress		10B. KIND OF BUSINESS OR INDUSTRY self-employed		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME PETER P. DAUM GERMANY				14. MOTHER'S MAIDEN NAME ? Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-34-4083 A		17. INFORMANT Arden A. Fields, Jr. 5221 Kramme Ave. 21225	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 410.01 Cardiac Tamponade				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 DAYS	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ACUTE INFECTIOUS MYOCARDIAL INFARCTION	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE 2+ MONTHS	
				(C) 1+ YEARS	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). HYPERTENSION - MODERATE					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (3) (this hospital) attended the deceased from NOVEMBER 29 1972 to DECEMBER 3 1972 that (3) (we) last saw the deceased alive on DECEMBER 3 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Theodore H. Cryer M.D.				23B. DATE SIGNED 12-3-72	
23C. PHYSICIAN'S NAME (Type) THEODORE H. CRYER M.D.				23D. ADDRESS SOUTH BALTIMORE GENERAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/6/72		24C. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	
24D. LOCATION Baltimore City, Maryland		24E. STATE (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. DEC 6 1972		25B. NAME OF REGISTRAR Andrew J. Walters		25C. FUNERAL DIRECTOR Walters Funeral Home Pratt & Stricker	
				ADDRESS Streets 21223	

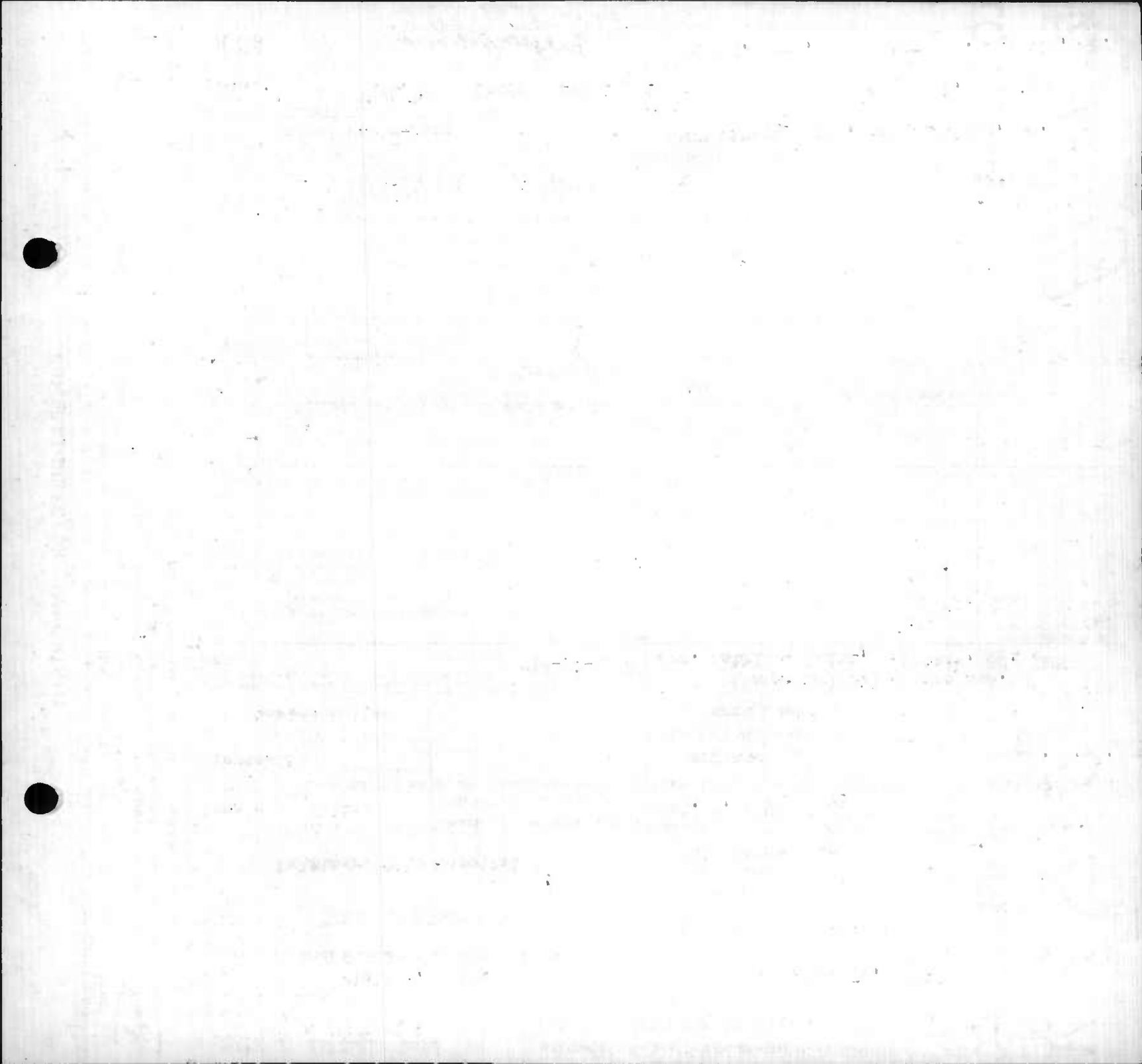




**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND-DEHM 72 11525		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 11525
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH
		Viola E. Ewing		November 30, 1972
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY		
31 Baltimore City Hospital		Maryland Baltimore		
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?
		Dundalk		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
		E. STREET AND NUMBER		
		201 Ashwood Road		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Oct. 8, 1899	73
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
Housewife				Maryland
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
Charles Bullen		Sarah Meeks		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT (Daughter) 873 Jaydee Ave.
No		218-22-6664		Mrs. Kathleen Raitt, Dundalk, Md. 21222
18. 410.91		CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		Acute Myocardial Infarction		
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		ASHD		
II		(C) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0		No		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from July 1972 to 11-27 1972, that (I) (we) last saw the deceased alive on 11-27 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE		23B. DATE SIGNED		
Rafael Perez-Mera		12/1/72		
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
Rafael Perez-Mera		8507 Liberty Road, Randallstown, Md.		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)	
Burial	12/4/72	Loudon Park Cemetery	Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS	
DEC 6 1972	John J. Duda	7922 Wise Ave. Dundalk, Md.		



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## STATE OF MARYLAND DEPT.

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO. 72 11526

BIRTH NO. 72 11526

1. NAME OF DECEASED (Type or Print) Bud Cox

2. DATE AND HOUR OF DEATH

24 Nov 72 1 30 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

31 BALTIMORE CITY HOSPS  
4940 Eastern Ave. BALTO, Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY Maryland Baltimore

C. CITY OR TOWN Edgemere

D. INSIDE CITY LIMITS?

YES ☐ NO ☒

E. STREET AND NUMBER

2602 SPARROWS PT RD.

5. SEX

Male

6. RACE

Caucasian

7. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

1 Mar 1889

9. AGE (In years (last birthday))

83

If Under 1 Tr. Months: Days: Hours: Min.

If Under 24 Hrs. Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

General Work

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

?

16. SOCIAL SECURITY NO.

219-40-2267

17. INFORMANT

BCH Records:

4940 Eastern Ave. ADDRESS

Baltimore, Md. 21224

18. 412.3 I

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Deteriorative HT Disease

yes.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 26 Mar 72 19 to 24 Nov 72 19 that (I) (we) last saw the deceased alive on 24 Nov 72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

Edmund Beacham M.D.

Attending Phys. ☐Med. Director ☒Staff Phys. ☒

23B. DATE SIGNED

24 Nov 72

23C. PHYSICIAN'S NAME (Type)

E. G. BEACHAM M.D.

23D. ADDRESS

4940 Eastern Ave. Baltimore, Md. 21224  
Baltimore City Hospitals, Balto Md.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

12-4-72

24C. NAME OF CEMETERY OR CREMATORY

Oak Lawn Cemetery

24D. LOCATION (City, town, or county) (State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

DEC 6 1972

25B. NAME OF REGISTRAR

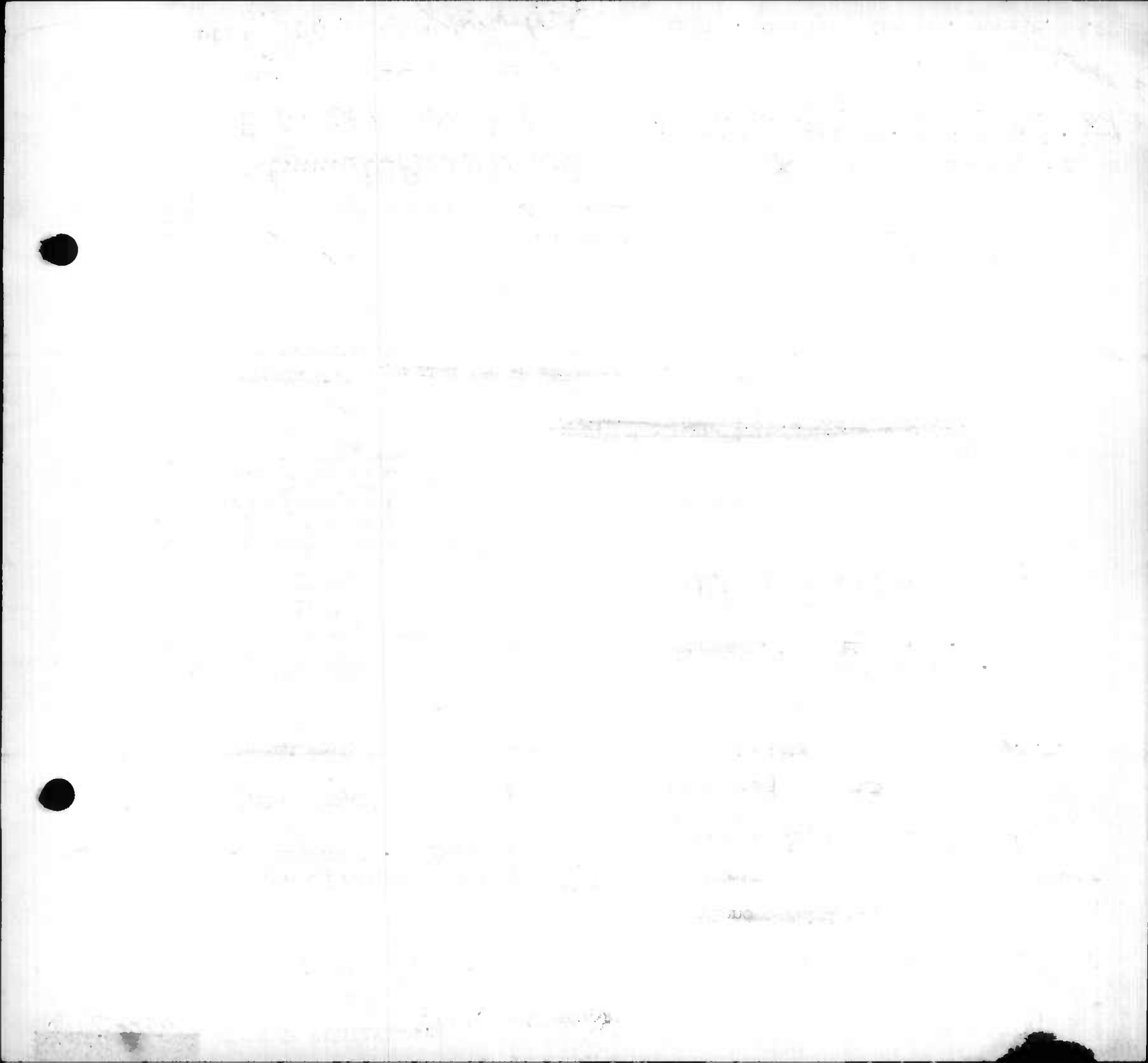
Sidney H. Hester

25C. FUNERAL DIRECTOR

John J. Duda

ADDRESS

7922 Wise Ave. Dundalk, Md. 21222



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## CERTIFICATE OF DEATH

REG. NO. 72 11527

BIRTH NO. 72 11527

1. NAME OF DECEASED

(Type or Print)

BOWERS, HARRY THOMAS

2. DATE AND HOUR OF DEATH

DECEMBER 1, 1972

6:45 A

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

VETERANS ADMINISTRATION HOSPITAL

3900 LOCH RAVEN BOULEVARD

BALTIMORE, MARYLAND 21218

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

BALTIMORE

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

1 N. BRADFORD STREET

5. SEX

MALE

6. RACE

CAUCASIAN

7. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

2-25-17

9. AGE (In years  
last birthday)

55

If Under 1 Yr.

Months: Days:

If Under 24 Hrs.

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Stock Clerk

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MD.

12. CITIZEN OF WHAT COUNTRY?

UNITED STATES

13. FATHER'S NAME

JOSEPH BOWERS

14. MOTHER'S MAIDEN NAME

MARGARET I. DUNN

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown)

YES

(If yes, give war or dates of service)

Apr 41 to 3-10-45

16. SOCIAL SECURITY NO.

217-09-11-08

17. INFORMANT VA HOSPITAL RECORDS

ADDRESS

3900 LOCH RAVEN BLVD, BALTIMORE, MD. 21218

18. 038.91

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Respiratory Arrest

unk

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Sepsis

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ☒ (this hospital) attended the deceased from OCTOBER 24 19 72 to DECEMBER 1 19 72,  
that ☒ (we) last saw the deceased alive on DECEMBER 1 19 72 and that in ☒ (our) opinion death occurred on the date  
and hour and from the causes stated above. ☒ (We) (did) (~~not~~) view the body after death.

23A. SIGNATURE

Jay P. Cannon, M.D.

EGREE

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☐

23B. DATE SIGNED

12/3/72

23C. PHYSICIAN'S  
NAME (Type)

JAY P. CANNON

MD EGREE

23D. ADDRESS

3900 Loch Raven Boulevard  
Baltimore, Maryland 2121824A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

burial

Dec 6 1972 Baltimore National Cemetery Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

DEC 6 1972

Disney Brothers

Disney Brothers, Inc 7110 Belair Road 06

TO: DIRECTOR, FBI  
FROM: SAC, NEW YORK  
SUBJECT: [Illegible]

[Illegible text block]

[Illegible text block]



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
STATE OF MARYLAND					CERTIFICATE OF DEATH					
BIRTH NO. 72 11528					REG. NO. 856 11528					
1. NAME OF DECEASED (Type or Print) <u>Cole, <del>Frances</del> FRANCES</u>					2. DATE AND HOUR OF DEATH <u>12/2/72</u> <u>1 02 PM</u>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Harbor View Nursing home</u>					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md</u> B. COUNTY <u>2719</u> C. CITY OR TOWN <u>BALTO</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>5507 High Gate</u> <u>DR.</u>					
5. SEX <u>FEMALE</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/10/90</u>	9. AGE (In years last birthday) <u>82</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>LATVIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>ISADORE ROBINSON</u>					14. MOTHER'S MAIDEN NAME					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Edward Cole</u> <u>Vienna VA</u> <u>10309 Hunt County</u>					
18. CAUSE OF DEATH <u>4/2/4 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Pneumonia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ASCVD with Chronic Brain Syndrome</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <u>0</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>0</u> 20A. AUTOPSY? (Yes or No) <u>0</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>0</u> 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>0</u> 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>0</u> 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>0</u> 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? <u>0</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 Days</u> <u>Years</u>					
22. I certify that <u>it</u> (this hospital) attended the deceased from <u>November 18</u> 19 <u>70</u> to <u>December 2</u> 19 <u>72</u> , that <u>it</u> (we) last saw the deceased alive on <u>December 2</u> 19 <u>72</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above <u>it</u> (We) (did) (did not) view the body after death.										
23A. SIGNATURE <u>Peter H. Rheinwein, MD</u> DEGREE					23B. DATE SIGNED <u>3 December 1972</u>			23C. PHYSICIAN'S NAME (Type) <u>PETER H. RHEINWEIN, MD</u> DEGREE		
23D. ADDRESS <u>HARBOR VIEW CONVALESCENT CENTER</u>					24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>					
24B. DATE <u>12/5/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>HEBREW YOUNG MEN</u>			24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 6 1972</u>			25B. NAME OF REGISTRAR <u>Shirley H. Heston</u>			25C. FUNERAL DIRECTOR <u>SOL LEVINSON &amp; BROS.</u>			ADDRESS <u>6010 REISTERSTOWN ROAD</u>	



1950

THE UNITED STATES OF AMERICA

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND - DEPT. OF HEALTH				BALTIMORE CITY HEALTH DEPARTMENT		72 11529	
BIRTH NO. 72 11529				REG. NO. _____			
CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print)		COHN, DOROTHY S.		2. DATE AND HOUR OF DEATH 4 DEC 72 443 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution's residence before admission) A. STATE B. COUNTY MARYLAND - CITY 2720			
FULL NAME OF HOSPITAL OR INSTITUTION		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
SINAI HOSP. BALTO, INC.				E. STREET AND NUMBER 4010 GLEN AVE. 21215			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-25-13	9. AGE (In years last birthday) 59	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HYMAN SILVER				14. MOTHER'S MAIDEN NAME LENA SCHLESSINGER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MR. THEODORE COHN, 4010 GLEN AVE. #21215			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DUE TO, OR AS A CONSEQUENCE OF: Cerebellar Cyst Weeks				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Basilar Artery Thrombosis Days							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 11-2-72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Cerebellar Mass		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11/27/72 to 12/4/72 and that (I) (we) last saw the deceased alive on 12/4/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Michael Schultz MD				23B. DATE SIGNED 4 Dec 72			
23C. PHYSICIAN'S NAME (Type) SCHULTZ, MICHAEL J. MD				23D. ADDRESS Sinai Hosp. Balto, Inc.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/5/72		24C. NAME OF CEMETERY OR CREMATORY BETH EL MEMORIAL PARK		24D. LOCATION (City, town, or county) (State) RANDALLSTOWN, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. DEC 6 1972		25B. NAME OF REGISTRAR Sidney H. Koston		25C. FUNERAL DIRECTOR SOB LIVINGSON & BROS., 6010 REISTERSTOWN ROAD			

FEB 27

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND-DEME

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

72 11530

BIRTH NO. 72 11530

1. NAME OF DECEASED

(Type or Print)

BARRASH, SALLY SARUBIN LEE

2. DATE AND HOUR OF DEATH

4 DECEMB 72 4<sup>45</sup>

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

SINAI Hosp of BALTO Inc

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE B. COUNTY

MARYLAND, BALTO. CO. 5300

C. CITY OR TOWN D. INSIDE CITY LIMITS?

BALTIMORE YES ☐ NO ☒

E. STREET AND NUMBER

1 SAMWOOD Ct. 21208

5. SEX

FEMALE

6. RACE

WHITE

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

5/30/32

9. AGE (in years last birthday)

40

10. Under 1 Yr. Months Days

11. Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

AT HOME

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MARYLAND

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

HERMAN SARUBIN

14. MOTHER'S MAIDEN NAME

LENA DUNNES

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

MR. STANLEY BARRASH, 1 SAMWOOD CT. #21208

18. 430.91

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE Intracerebral bleed 3 da

DUE TO, OR AS A CONSEQUENCE OF:

(B) Cerebral aneurysm Weeks

DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)

(APPROX.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/2 19 72 to 12/4 19 72

that (I) (we) last saw the deceased alive on 12/4 19 72 and that in (my) (our) opinion death occurred on the date

and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Michael Schultz MD

DEGREE

Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED

4 Dec 72

23C. PHYSICIAN'S NAME (Type)

SCHULTZ, MICHAEL M.D.

DEGREE

23D. ADDRESS

Sinai Hosp Balto Inc.

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

12/5/1972

24C. NAME OF CEMETERY OR CREMATORY

BETH TFILOH

24D. LOCATION

BALTIMORE, MARYLAND

(City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT.

DEC 6 1972

25B. NAME OF REGISTRAR

Sidney Indestrom

25C. FUNERAL DIRECTOR

SOB LEVINSON & BROS., 6010 REISTERSTOWN ROAD

ADDRESS

UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF THE ASSISTANT SECRETARY  
WASHINGTON, D. C.

TO THE SECRETARY OF AGRICULTURE  
FROM THE ASSISTANT SECRETARY

RE: [illegible]

Very respectfully,  
[illegible signature]

Enclosed for the Secretary are [illegible]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
72 11531 STATE OF MARYLAND					REG. NO. 72 11531						
BIRTH NO. 72 11531					STATE OF MARYLAND						
1. NAME OF DECEASED (Type or Print) <i>Harry Bender</i>					2. DATE AND HOUR OF DEATH <i>December 4 / 72 4 P.</i> M.						
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)						
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>00 3926 Annellen Road</i>					A. STATE <i>Maryland</i>		B. COUNTY <i>1511</i>		C. CITY OR TOWN <i>Baltimore</i>		
					D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <i>3926 Annellen Road</i>				
5. SEX <i>Male</i>		6. RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>JUNE 10, 1897</i>		9. AGE (in years lost birthday) <i>75</i>		10. CITIZEN OF WHAT COUNTRY? <i>USA.</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Self Employed Watch Repairer</i>					10B. KIND OF BUSINESS OR INDUSTRY <i>Watch Repairer</i>					11. BIRTHPLACE (State or foreign country) <i>Russia</i>	
13. FATHER'S NAME <i>Zelig Bender</i>					14. MOTHER'S MAIDEN NAME <i>Gittel Glazer</i>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service) <i>No.</i>					16. SOCIAL SECURITY NO. <i>218-32-2764</i>		17. INFORMANT <i>Mrs Eva Bender-3304 Devonshire</i>				
18. <i>412.4 + 250.9</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <i>ARTERIOSCLEROTIC CARDIO - VASCULAR DISEASE</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10 years</i>						
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.					(B) DUE TO, OR AS A CONSEQUENCE OF: <i>DIABETES MELLITUS</i>					(C) DUE TO, OR AS A CONSEQUENCE OF: <i>20 years</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>II</i>											
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?						
22. I certify that (I) (this hospital) attended the deceased from <i>1/11</i> 19 <i>60</i> to <i>9/17</i> 19 <i>71</i> , that (I) <del>(we)</del> last saw the deceased alive on <i>9/10</i> 19 <i>71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> (did not) view the body after death.											
23A. SIGNATURE <i>Irvin Kaplan MD</i>					23B. DATE SIGNED <i>12/5/72</i>			23C. PHYSICIAN'S NAME (Type) <i>IRVIN KAPLAN</i>			
23D. ADDRESS <i>1295 BROADWAY</i>											
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Dec 5/72</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Broad Terrace</i>			24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>				
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 6 1972</i>		25B. NAME OF REGISTRAR <i>Johny [illegible]</i>			25C. FUNERAL DIRECTOR <i>504 [illegible] - 6010 [illegible]</i>						

2nd of July 1864

Dear Mother

I have just received your letter of the 29th and was glad to hear from you. I am well and hope these few lines will find you the same.

I have not much news to write at present. I am still in the same place and doing the same work. I hope to hear from you soon.

I am, dear Mother, ever your affectionate son.

Yours truly,  
John Smith



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

N-620		72 11532		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		X REG. NO. 72 11532	
BIRTH NO.				STATE OF MARYLAND-DETH			
1. NAME OF DECEASED (Type or Print) <b>Edward REARDON NORRIS</b>				2. DATE AND HOUR OF DEATH <b>12/1/72 8:40 AM</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>CARROLL 5600</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>UNIVERSITY OF MARYLAND 38 HOSPITAL</b>				C. CITY OR TOWN <b>HENRYTON</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>HENRYTON STATE HOSPITAL</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/13/07</b>	9. AGE (in years lost birthday) <b>65</b>	If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM D. NORRIS</b>				14. MOTHER'S MAIDEN NAME <b>ANNA M. HUSTER</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MRS GRACE N. REMKE</b> ADDRESS <b>1 BICKLE HILL RD. ARISTOWN, MD.</b>			
18. <b>579.01-250.4</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>SEPTIC SHOCK</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>GRAM NEGATIVE SEPSIS</b> <b>UTI</b>				CAUSE OF DEATH <b>SEPTIC SHOCK</b>			
				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b> <b>3 days</b> <b>3 days</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>DIABETES</b>							
19A. DATE OF OPERATION <b>12/1/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) 1 (Month) 1 (Day) 1 (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>11/13</b> 19 <b>72</b> to <b>12/1</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>12/1</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Thomas E. Murphy Jr.</b> DEGREE				23B. DATE SIGNED <b>12/1/72</b>		23C. PHYSICIAN'S NAME (Type) <b>Thomas E. Murphy Jr.</b> DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>12-5-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>	
24D. LOCATION <b>Baltimore</b>				24E. CITY, TOWN, OR COUNTY <b>MD.</b>		24F. STATE <b>MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 6 1972</b>		25B. NAME OF REGISTRAR <b>Sidney W. Haight</b>		25C. FUNERAL DIRECTOR <b>Sidney W. Haight</b>		25D. ADDRESS <b>Sykesville, Md.</b>	



113



AS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
72 11533 CERTIFICATE OF DEATH

REG. NO. 72 11533

STATE OF MARYLAND - DIME

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MOXLEY, ORPHA I ONE

2. DATE AND HOUR OF DEATH  
DECEMBER 2, 1972

19:00P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

ST AGNES HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
MARYLANDB. COUNTY  
HOWARD COUNTYC. CITY OR TOWN  
GLENWOOD

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

RT 97 WASHINGTON RD

5. SEX

FEMALE

6. RACE

CAUCASIAN

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

11-15-91

9. AGE (In years  
last birthday)

81

If Under 1 Yr.  
Months: Days:If Under 24 Hrs.  
Hours: Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Homemaker

10B. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U S A

13. FATHER'S NAME

JOHN ENGLE

14. MOTHER'S MAIDEN NAME

SOPHIA (LUTZ)

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

216-07-4000 ST. AGNES HOSP RECORDS

17. INFORMANT

ADDRESS

18. 412.31

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Cardiac arrest  
coronary arteries disease, +  
Respiratory failure

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ☒ (this hospital) attended the deceased from NOVEMBER 9 1972 to DECEMBER 2 1972,  
that ☒ (we) last saw the deceased alive on DECEMBER 2 1972 and that ☒ (our) opinion death occurred on the date  
and hour and from the causes stated above. ☒ (We) (did) ☒ (not) view the body after death.

23A. SIGNATURE

Edward G. Romero

DEGREE

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☐

23B. DATE SIGNED

12-2-72

23C. PHYSICIAN'S  
NAME (Type)

Edward G. Romero

DEGREE

23D. ADDRESS

St. Agnes Hospital

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

12-6-72

24C. NAME OF CEMETERY OR CREMATORY

Mortuary Chapel Center

24D. LOCATION

Lanham

(City, town, or county)

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

DEC 6 1972

25B. NAME OF REGISTRAR

Andrew H. Heston

25C. FUNERAL DIRECTOR

Mary W. Knight

ADDRESS

Lynchville, Md.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Bodily burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 11534

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 72 11534

STATE OF MARYLAND

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JACK BERNIS. (BERNSTEIN)

2. DATE AND HOUR OF DEATH

11-29-72

11:25 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

SINAI HOSPITAL OF BALTIMORE INC.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

1 E. UNIVERSITY PARKWAY, APT. 505

5. SEX

MALE

6. RACE

WHITE

7. MARRIED ☒

NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

5-1-07

9. AGE (In years last birthday)

65

10. Under 1 Year

Months Days

11. Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

MERCHANT

10B. KIND OF BUSINESS OR INDUSTRY

RETAIL

11. BIRTHPLACE (State or foreign country)

NEW YORK, NEW YORK

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

SAMUEL BERNIS

14. MOTHER'S MAIDEN NAME

?

15. Was Deceased Ever in U. S. Armed Forces (Yes, no or unknown) (If yes, give war or dates of service)

YES

W.W. II AIR FORCE

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

MRS. GERTRUDE BERNIS, 1 E. UNIVERSITY PKWY, APT. 505

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

— ACUTE RENAL FAILURE  
RETROPERITONEAL.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

DOES PULMONARY EMBOLISM  
'CARCINOMA OF ESOPHAGUS (OPERATED)  
10/5/69

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

3 DAYS

3 DAYS

MONTHS

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

11-20-72

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

CARCINOMA OF ESOPHAGUS GASTRIC ULCER

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11-15-72 to 11-29-72 that (I) (we) last saw the deceased alive on 11-29-72 and that in (my) (our) opinion death occurred on the date and hour end from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

OUTERREZ M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

11-29-72

23C. PHYSICIAN'S NAME (Type)

Felix OUTERREZ M.D.

23D. ADDRESS

SINAI HOSPITAL BALTIMORE

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

12/3/72

24C. NAME OF CEMETERY OR CREMATORY

BETH TFILOH

24D. LOCATION

(City, town, or county)

BALTIMORE, MARYLAND

(State)

25A. DATE REC'D BY HEALTH DEPT.

DEC 6 1972

25B. NAME OF REGISTRAR

Sidney Robinson

25C. FUNERAL DIRECTOR

SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD

ADDRESS

Handwritten text at the top of the page, including "1945" and "10-15-45".

Handwritten text in the upper middle section, including "DIRECT" and "11/1/45".

Handwritten text in the middle section, including "10-15-45" and "11-1-45".

Handwritten text in the lower middle section, including "11-1-45" and "11-1-45".

Handwritten text in the lower section, including "11-1-45" and "11-1-45".

Handwritten text at the bottom of the page, including "11-1-45" and "11-1-45".



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 11535

REG. NO.

BIRTH NO.

STATE OF MARYLAND-DHMH

1. NAME OF DECEASED (Type or Print) Rose Caplan		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 11 Day 30 Year 72 Hour 8:45 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Sinai Hospital		3. DATE PRONOUNCED DEAD Month 11 Day 30 Year 72 Hour 8:45 P.M.	
6. SEX Female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 10. AGE (In years last birthday) 88 84		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country) RUSSIA		E. STREET AND NUMBER 4420 Eve May Road	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME HYMAN ROSINSKY	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		14B. KIND OF BUSINESS OR INDUSTRY AT HOME	
15. MOTHER'S MAIDEN NAME EDITH ?		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO	
17. SOCIAL SECURITY NO. 213-74-8685		18. INFORMANT MRS. ANNA GIVNER, 3811 DEEP WILLOW AVE. #21208	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 6800 blk. Reisterstown R. 34' S. of Labyrinth Rd.		22D. TIME OF INJURY (APPROX.) 11 21 72 12:01 P.M.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Pedestrian struck by auto	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <i>W P Mulloy</i> M.D. EXAMINER'S NAME (Type): William P. Mulloy, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: 12-1-72	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/3/72	
24C. NAME OF CEMETERY or CREMATORY WORKMEN CIRCLE		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. DEC 6 1972		25B. NAME OF REGISTRAR <i>Andrey In...</i>	
25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		ADDRESS	



1950

UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF THE ASSISTANT SECRETARY FOR CROPS AND LIVESTOCK

WASHINGTON, D. C.

January 1, 1950

Dear Sir:

I am pleased to inform you that the

Department has received your letter of

December 15, 1949, regarding the

proposed changes in the

regulations governing the

operation of the

Department's

programs.

The Department is currently reviewing

the proposed changes and will

submit a report to the

Secretary of Agriculture.

I am sure that you will understand

the need for this review.

Very truly yours,

Assistant Secretary for Crops and Livestock

Enclosure

1950

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 11536

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 72 11536

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Ruth London

2. DATE AND HOUR OF DEATH

11/30/72

8:45 P.M.

STATE OF MARYLAND - DEATH

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

42 Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

B. COUNTY

Maryland Baltimore

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

7908 Dunhill Village Circle

5. SEX

Female

6. RACE

White

7. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☒

8. DATE OF BIRTH

12/15/99

9. AGE (In years  
last birthday)

72

If Under 1 Yr.

Months

Days

If Under 24 Hrs.

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Buyer

10B. KIND OF BUSINESS OR INDUSTRY

Ladies clothing

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Mendel Mikel

14. MOTHER'S MAIDEN NAME

Rose Pushkin

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown)

No

16. SOCIAL  
SECURITY NO.

216-03-6927

17. INFORMANT

Maynard London - 8512 Church Lane

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Hypernephroma

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

17 mos

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/20 19 72 to 11/30 19 72  
that (I) (we) last saw the deceased alive on 11/30 19 72 and that (in my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Karen M. Lichterfeld MD

DEGREE

Attending ☐Med. ☐Staff ☐

23B. DATE SIGNED

11/30/72

23C. PHYSICIAN'S  
NAME (Type)

Karen M. Lichterfeld MD

DEGREE

23D. ADDRESS

Sinai Hospital

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

Dec 3/72

24C. NAME OF CEMETERY OR CREMATORY

Workmen Circle

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

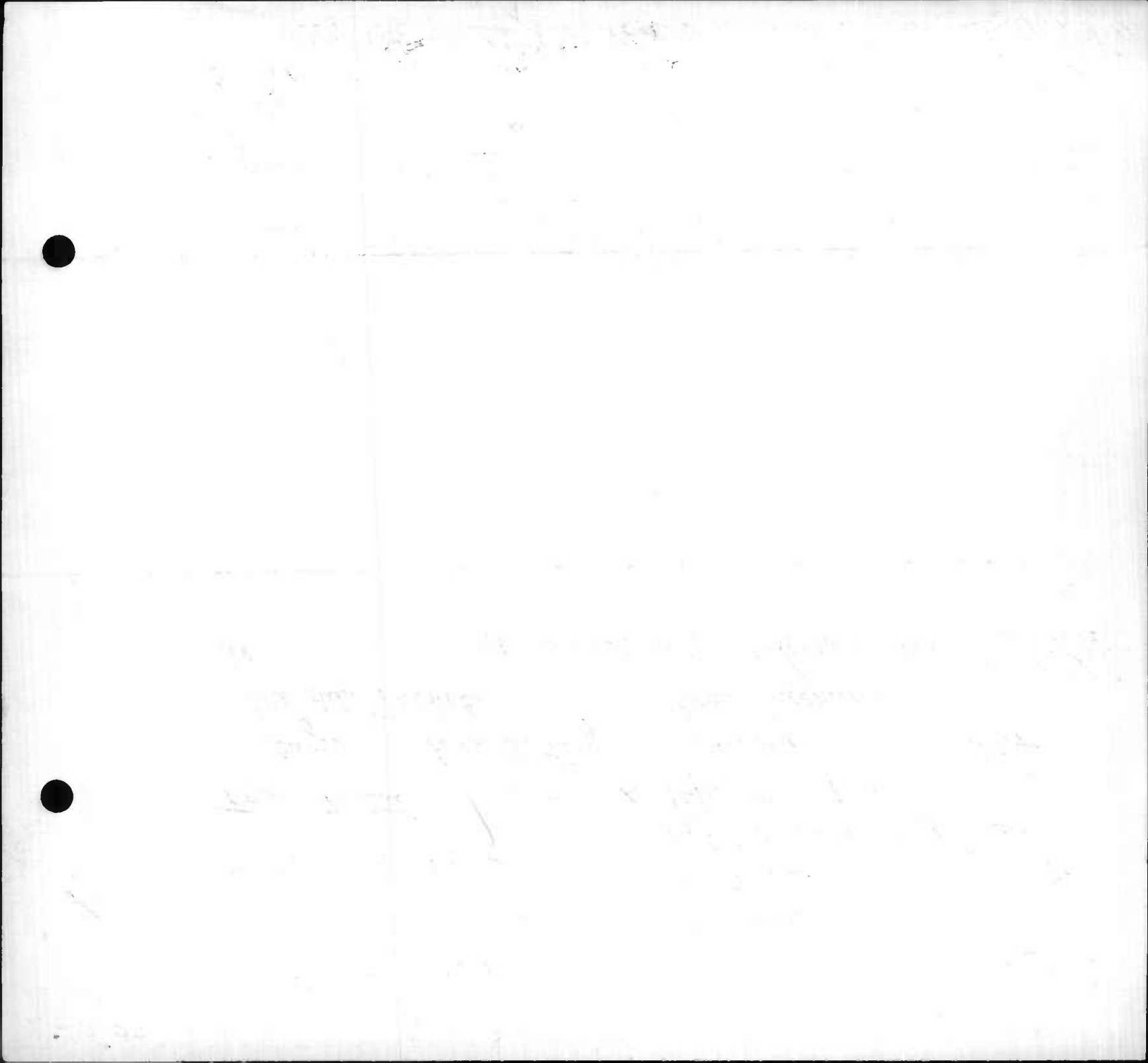
DEC 6 1972

25B. NAME OF REGISTRAR

Sidney M. ...

25C. FUNERAL DIRECTOR

... - 6000 Rock...



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-5001

72 11537

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 72 11537  
STATE OF MARYLAND-DEME

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

ISRAEL

COHN

2. DATE AND HOUR OF DEATH  
Dec 2 1972 11 AM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

4 Sinai Hospital of Balt.

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE B. COUNTY

Ma.

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

6807 Park Hgts Ave Apt 3 J

5. SEX

Male

6. RACE

White

7. MARRIED ☒ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

9/12/1899

9. AGE (in years last birthday) 73

10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Self Employed

10B. KIND OF BUSINESS OR INDUSTRY

Steel Shelving Co

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Simon Cohn

14. MOTHER'S MAIDEN NAME

Julia ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS 31215

Mrs. Blanche Cohn 6807 Park Heights Ave. Apt 3J

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Acute myocardial infarction

(B) DUE TO, OR AS A CONSEQUENCE OF:

with recurrent myocardial infarction

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

8 months

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1961 to Dec 2 1972 that (I) (we) last saw the deceased alive on Dec 2 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.

23A. SIGNATURE

23C. PHYSICIAN'S NAME (Type)

SEYMOUR H RUBIN

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

12/2/72

23D. ADDRESS

5415 Park Heights Ave

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

12/3/1972

24C. NAME of CEMETERY or CREMATORY

Tifereth Israel Anshe Sfard

24D. LOCATION

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

DEC 6 1972

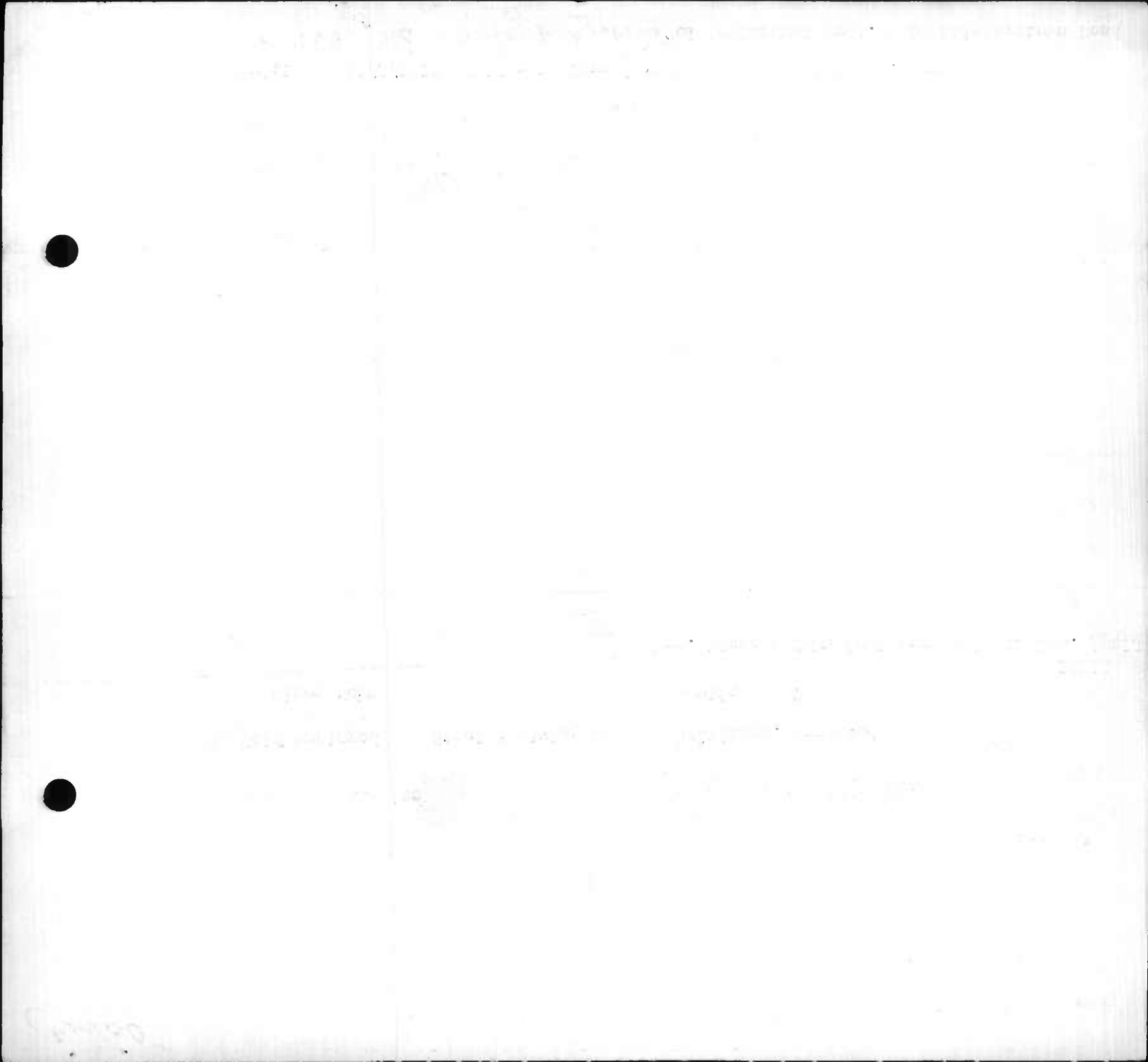
25B. NAME OF REGISTRAR

Andrey Indeston

25C. FUNERAL DIRECTOR

Sol Levinson & Bros. 6010 Reisterstown Road

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 11538	
72 11538				STATE OF MARYLAND-DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		SADYE K. MORRIS		Dec 3, 1972 12:04 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
6101 PARK HEIGHTS AVENUE, APT. 3G			MARYLAND		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			BALTIMORE		YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			6101 PARK HEIGHTS AVENUE, APT. 3G		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days
FEMALE	WHITE	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	4/6/1888	84	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
HOUSEWIFE		AT HOME		KENT COUNTY, MARYLAND	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
BENJAMIN KRAMER		MARTHA RAFFEL		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
NO		218-54-2810		MISS LEONA S. MORRIS, 6101 PARK HEIGHTS AVENUE APT. 3G	
18. CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			10 days		
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			CVA		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) Cerebral atherosclerosis		
			(C) 18 yrs		
II			18 yrs		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			ASHTD renal myocardial infarction		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Oct 19 55 to 3 Dec 1972, that (I) (we) last saw the deceased alive on 1 Dec 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
MARVIN H. DAVIS, M.D.				4 Dec 1972	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
MARVIN H. DAVIS, M.D.				8507 Liberty Rd 21133	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		12/4/72		MIKRO KODESH	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
DEC 6 1972		Audrey Johnson		SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	





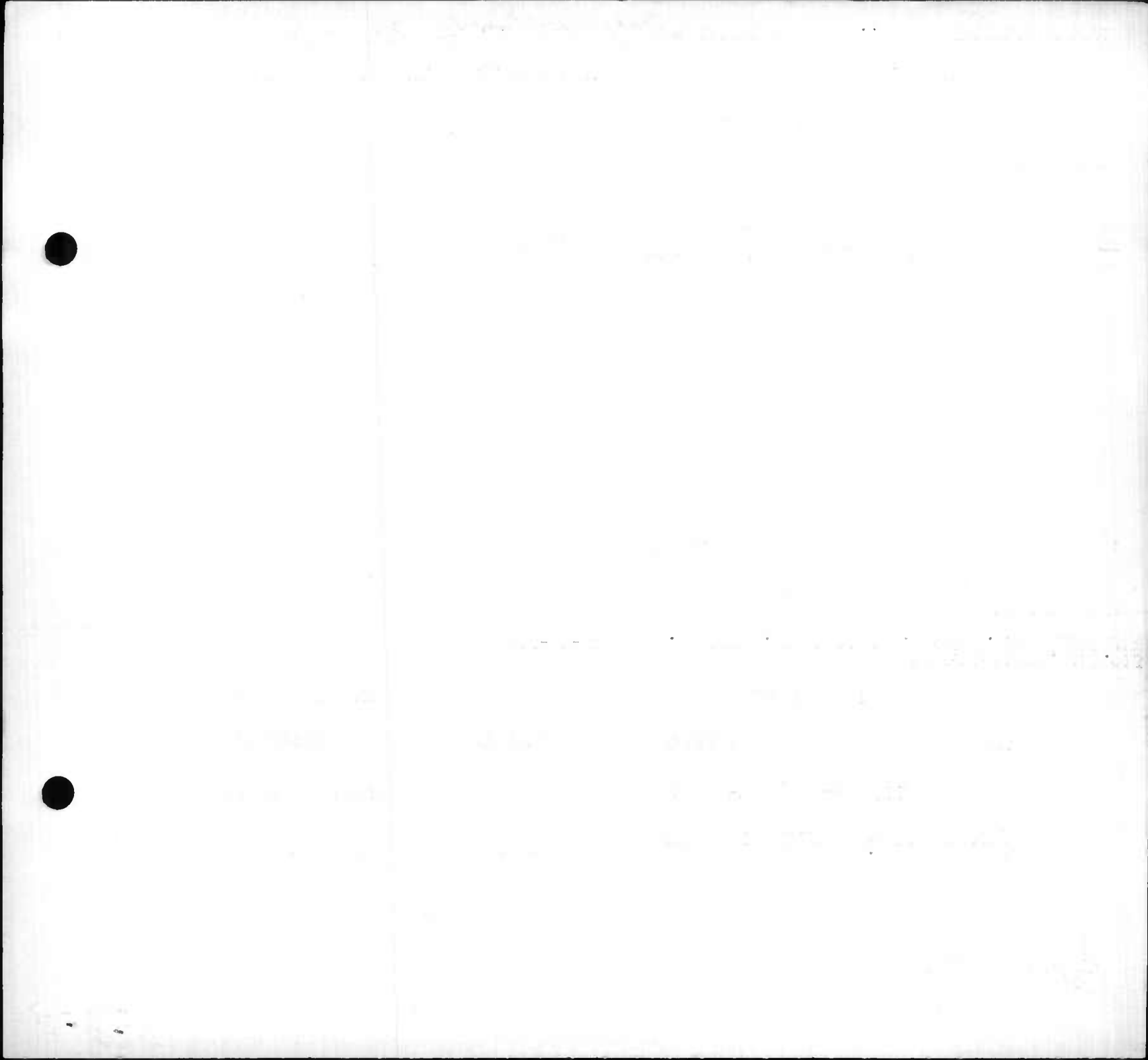
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
72 11539 CERTIFICATE OF DEATH

REG. NO. 72 11539  
STATE OF MARYLAND-DHMH

BIRTH NO. 72 11539		1. NAME OF DECEASED (Type or Print) <b>FRIEDLANDER, LILLIAN</b>		2. DATE AND HOUR OF DEATH <b>Dec. 2, 1972, 9<sup>10</sup> P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>SINAI HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2717</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2500 W. BELVEDERE AVENUE</b> <del>618 HUNTERDALE AVE. BALTIMORE</del>		
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/20/99</b>	9. AGE (In years last birthday) <b>73</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>ENGLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>? FRIEDMAN</b>		
14. MOTHER'S MAIDEN NAME <b>RACHEL ?</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		
16. SOCIAL SECURITY NO. <b>214-68-3196</b>			17. INFORMANT <b>MR. HARRY M. FRIEDLANDER, 2500 W. BELVEDERE AVE</b>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ACUTE MYOCARDIAL INFARCTION</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>ATHEROSCLEROTIC HEART DISEASE</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Dec. 1, 1972</b> to <b>Dec. 2, 1972</b> that (I) (we) last saw the deceased alive on <b>Dec. 2, 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Lillian</b>			23B. DATE SIGNED <b>Dec. 2, 72</b>		23C. PHYSICIAN'S NAME (Type) <b>PAUL PINTO</b>
23D. ADDRESS <b>SINAI HOSPITAL, BALTO. MD.</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12/4/72</b>		24C. NAME of CEMETERY or CREMATORY <b>ANSHE EMUNAH</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 6 1972</b>		25B. NAME OF REGISTRAR <b>Sidney H. Heston</b>		25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 11540 BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO. 72 11540

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

BERMAN ELEANOR JOAN

2. DATE AND HOUR OF DEATH

12-2-72

12:30 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

UNIVERSITY HOSPITAL

38

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

BALTO

5300

C. CITY OR TOWN

OWINGS MILLS

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

ROSEWOOD &amp; LANE

5. SEX

FEMALE

6. RACE

WHITE

7. MARRIED ☐NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

8/24/49

9. AGE (In years)

lost birthday 23

If Under 1 Yr.

Months: Days: Hours: Min.

If Under 24 Hrs.

Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

NONE

10B. KIND OF BUSINESS OR INDUSTRY

NONE

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MD

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

LOUIS BERMAN

14. MOTHER'S MAIDEN NAME

ROSALIE BURK

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

NO

17. INFORMANT

LOUIS BERMAN - 5904 BLAND AVENUE

ADDRESS

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE Bleeding through tracheostomy tube from erosion of tube into innominate artery.

(B) Tracheostomy

DUE TO, OR AS A CONSEQUENCE OF:

(C) Severe pneumonia left lung &amp; Multiple abscesses of left lung.

Multisystemic pseudomonas infection of

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

4/22

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

left pneumonia

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/3 1972 to 12/2 1972 that (I) (we) last saw the deceased alive on 12/2 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Tawfik M. Tamimi

M.D.

Attending Phys. ☐Med. Director ☐Staff Phys. ☐

23B. DATE SIGNED

12/2/72

23C. PHYSICIAN'S NAME (Type)

TAWFIK M. TAMIMI

23D. ADDRESS

UNIV. MD. HOSP.

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

DEC 3/72

24C. NAME OF CEMETERY or CREMATORY

TIFERETH ISRAEL

24D. LOCATION (City, town, or county) (State)

ROSEDALE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.

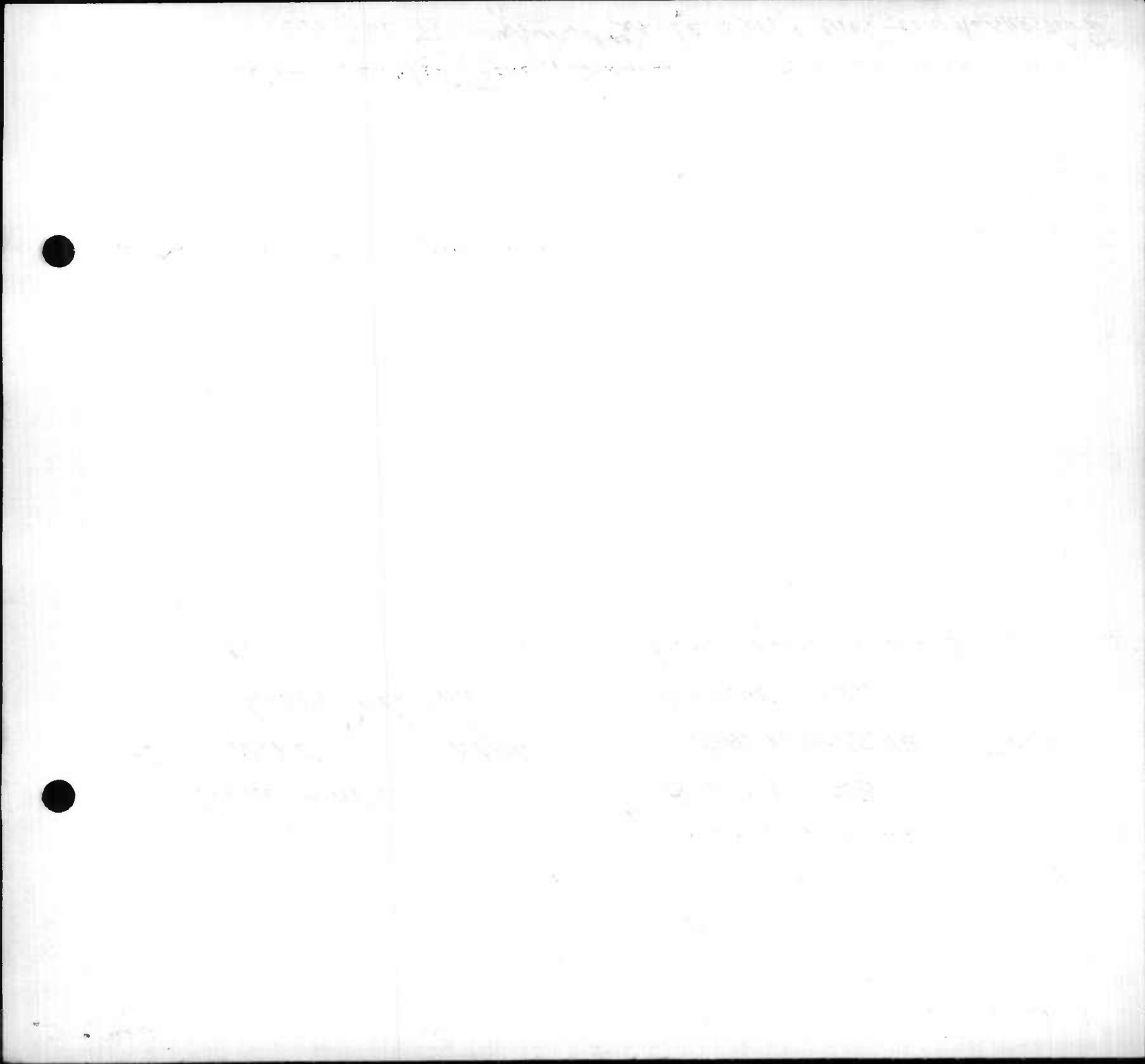
DEC 6 1972

25B. NAME OF REGISTRAR

Audrey Whitford

25C. FUNERAL DIRECTOR

LEVINSON &amp; BROS - 6010 REISTERSTOWN ROAD



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 11541 BALTIMORE CITY HEALTH DEPARTMENT				72 11541	
CERTIFICATE OF DEATH				STATE OF MARYLAND - DHMH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		LYDIA F. WELLSLAGER		12/1/72 10 <sup>00</sup> P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  90 House in the Pines, Belair, Rd.			A. STATE Maryland B. COUNTY 102		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN Baltimore,		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 134 S. Curley Street		
5. SEX F.	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/30/90	9. AGE (In years lost birthday) 82	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME James Edward Mahorney		14. MOTHER'S MAIDEN NAME Annie Hagert		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Mr. John B. Wellslager 134 S. Curley St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Cachexia; Multiple Drains; Possible Recurrent Bleeding.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Multiple Stroke (B) Antecedent Cause DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic Cardiovascular Disease (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months year	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/20/1972 to 12/1/1972, that (I) (we) last saw the deceased alive on 12/1/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Albert B. Bradley				23B. DATE SIGNED 12/2/72	
23C. PHYSICIAN'S NAME (Type) ALBERT B. BRADLEY, M.D.				23D. ADDRESS 4900 Belair Rd. Balto., Md. 21206	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/5/72		24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. DEC 6 1972			
25B. NAME OF REGISTRAR Andrew J. Weston		25C. FUNERAL DIRECTOR John A. Moran, Inc. 3000 E. Baltimore St. Baltimore, Md. 21224			

17

THE UNIVERSITY OF CHICAGO PRESS

THE UNIVERSITY OF CHICAGO PRESS

THE UNIVERSITY OF CHICAGO PRESS

THE UNIVERSITY OF CHICAGO PRESS

THE UNIVERSITY OF CHICAGO PRESS

THE UNIVERSITY OF CHICAGO PRESS

THE UNIVERSITY OF CHICAGO PRESS

THE UNIVERSITY OF CHICAGO PRESS

THE UNIVERSITY OF CHICAGO PRESS

THE UNIVERSITY OF CHICAGO PRESS

THE UNIVERSITY OF CHICAGO PRESS

THE UNIVERSITY OF CHICAGO PRESS

THE UNIVERSITY OF CHICAGO PRESS

THE UNIVERSITY OF CHICAGO PRESS

THE UNIVERSITY OF CHICAGO PRESS

FUNERAL DIRECTOR: IMPORTANT

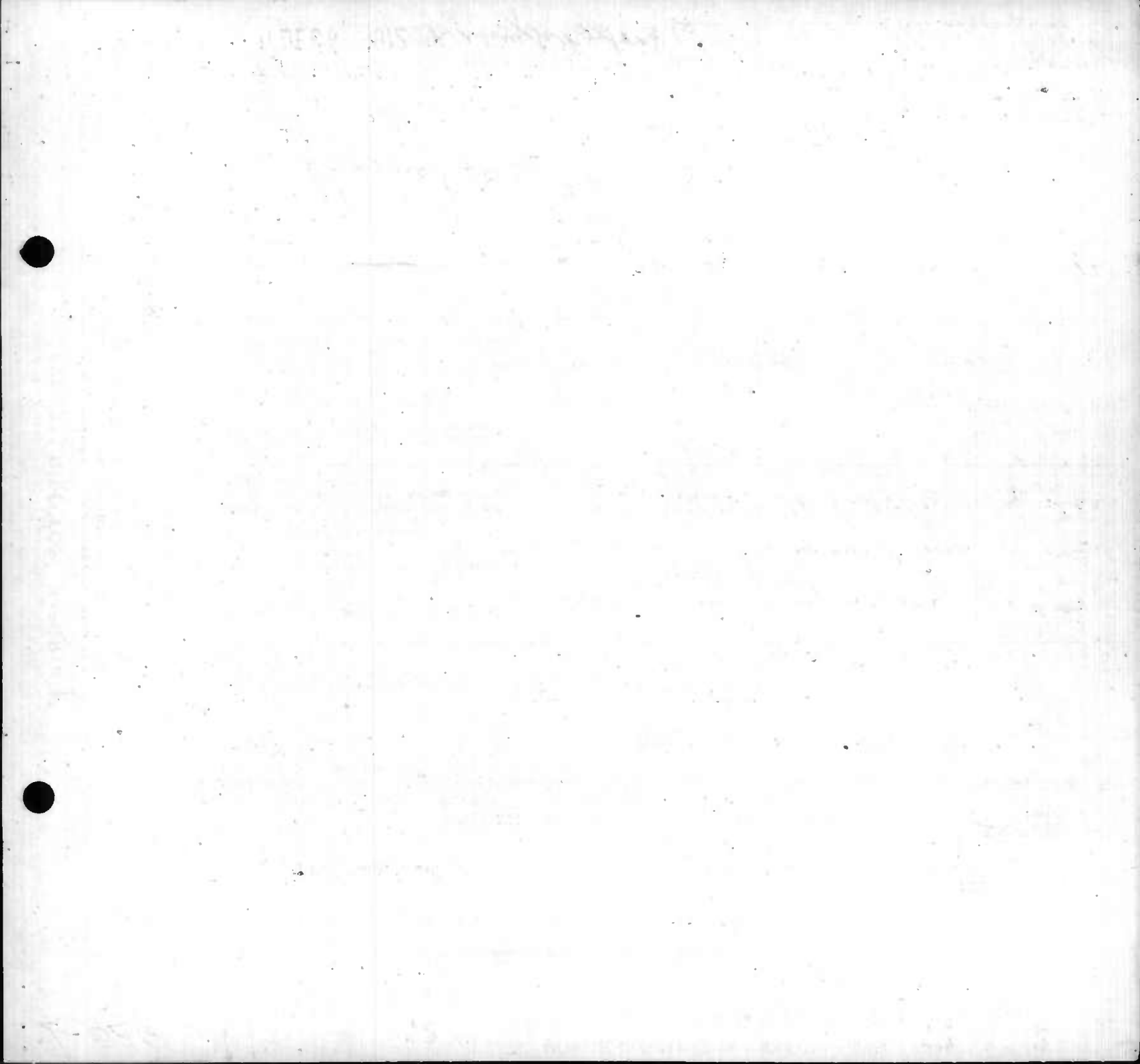
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
72 11542 CERTIFICATE OF DEATH

REG. NO. 72 11542  
STATE OF MARYLAND-DHMH

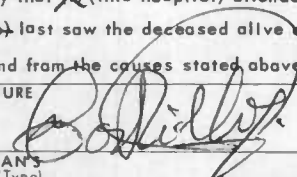
BIRTH NO. 72 11542		1. NAME OF DECEASED (Type or Print) <u>James C. Ingram</u>		2. DATE AND HOUR OF DEATH <u>12/01/72</u> <u>8</u> <u>P</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <u>42 Sinai Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2717</u>		C. CITY OR TOWN <u>Baltimore</u>	
5. SEX <u>male</u>		6. RACE <u>caucasian</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>2/22/1898</u>		9. AGE (in years last birthday) <u>74</u>		10. UNDER 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steam-fitter</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Heating</u>		11. BIRTHPLACE (State or foreign country) <u>Shreveport, Louisiana</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>333 18 11531</u>		17. INFORMANT <u>Thelma Ingram</u>	
18. <u>412.31</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Acute pulmonary edema</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>arteriosclerotic heart disease</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>cerebral thrombosis</u>		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>hypertension</u>		<u>4 years</u>	
(C) <u>None</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>Nov 26</u> 19 <u>57</u> to <u>Dec 1</u> 19 <u>72</u> , that (I) ( <del>we</del> ) lost saw the deceased alive on <u>Dec 1</u> 19 <u>72</u> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <u>Manuel Levin M.D.</u>		23B. DATE SIGNED <u>12/2/72</u>		23C. PHYSICIAN'S NAME (Type) <u>Manuel Levin, M.D.</u>	
23D. ADDRESS <u>6101 Park Heights Avenue</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/05/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Woodlawn, Maryland</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 6 1972</u>		25B. NAME OF REGISTRAR <u>Adrian Johnston</u>		25C. FUNERAL DIRECTOR <u>John T. Spensbury Jr.</u>	
25D. ADDRESS <u>6411 Windsor Mill Rd.</u>					





**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 11543	
72 11543 CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>BREWER, ROSE F.</b>		2. DATE AND HOUR OF DEATH <b>12-2-72 6<sup>15</sup> p.m.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1207</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>"The Union Memorial Hospital"</b> <b>74</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Female</b>		6. RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>house wife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>home</b>		8. DATE OF BIRTH <b>05-07-93</b> 9. AGE (In years last birthday) <b>79</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>WILLIAM LANNON</b>	
14. MOTHER'S MAIDEN NAME <b>FERGUSON</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>219 16 6592</b>	
17. INFORMANT <b>EILEEN BAKER</b>		ADDRESS <b>same address</b>			
18. <b>230.91</b>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <b>Hyperosmolar coma</b> DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>C.V.A. and dehydration</b> DUE TO, OR AS A CONSEQUENCE OF:			
		(C) <b>Diabetes mellitus</b>			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Hypertension</b>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>November 20 1972</b> to <b>December 2 1972</b> , that (I) <del>was</del> last saw the deceased alive on <b>December 2 1972</b> and that (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> (did) <del>did not</del> view the body after death.					
23A. SIGNATURE 				23B. DATE SIGNED <b>December 2 1972</b>	
23C. PHYSICIAN'S NAME (Type) <b>WALTER CASTILLO</b>		23D. ADDRESS <b>201-E, 33rd Street, Baltimore Maryland 21218</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>12/6/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Medowridge Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Elkridge Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 6 1972</b>		25B. NAME OF REGISTRAR <b>Sidney H. Heston</b>	
25C. FUNERAL DIRECTOR <b>John T. Storsbury</b>		ADDRESS <b>6411 Windsor Mill Rd.</b>			

REPORT OF THE COMMISSIONER OF THE GENERAL LAND OFFICE

TO THE HOUSE OF REPRESENTATIVES

IN SENATE, JANUARY 18, 1855

BY THE COMMISSIONER, J. M. SMITH

WASHINGTON: GPO: 1855

PRINTED BY THE COMMISSIONER

OF THE GENERAL LAND OFFICE

WASHINGTON: 1855

THE COMMISSIONER OF THE GENERAL LAND OFFICE

REPORTS TO THE HOUSE OF REPRESENTATIVES

IN SENATE, JANUARY 18, 1855

BY THE COMMISSIONER, J. M. SMITH

WASHINGTON: GPO: 1855

PRINTED BY THE COMMISSIONER

OF THE GENERAL LAND OFFICE

WASHINGTON: 1855

THE COMMISSIONER OF THE GENERAL LAND OFFICE

REPORTS TO THE HOUSE OF REPRESENTATIVES

IN SENATE, JANUARY 18, 1855

BY THE COMMISSIONER, J. M. SMITH

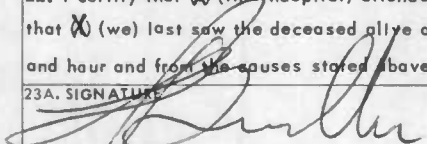
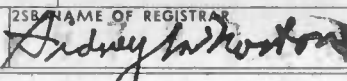
WASHINGTON: GPO: 1855

PRINTED BY THE COMMISSIONER

OF THE GENERAL LAND OFFICE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
72 11544 CERTIFICATE OF DEATH									
REG. NO. 72 11544									
BIRTH NO.		1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
		CLARIDGE, WILLIAM				DECEMBER 2, 1972 1:30P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)				STATE OF MARYLAND - DISTRICT			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE		B. COUNTY	
40 ST. AGNES HOSPITAL						MARYLAND		BALTIMORE 21228	
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
MALE		CAUCASIAN		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		04 26 85		87	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?	
WATCHMAN				MARYLAND				U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
HARRY CLARIDGE				UNKNOWN					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT			
No				218101480		RECORDS OF ST. AGNES HOSPITAL			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO, OR AS A CONSEQUENCE OF:					
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (X) (this hospital) attended the deceased from NOVEMBER 27 19 72 to DECEMBER 2 19 72, that (X) (we) last saw the deceased alive on DECEMBER 2 19 72 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.									
23A. SIGNATURE				23B. DATE SIGNED					
				12-2-72					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
L. BUCKLER, M.D.				ST. AGNES HOSPITAL					
				CATON & WILKENS AVES. BALTO., MD. 21229					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county)		24E. STATE	
BURIAL		12-5-72		NEW CATHEDRAL CEMETERY		BALTIMORE		MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
DEC 6 1972				HUBBARD FUNERAL HOME		4107 WILKENS AVE. 21229			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 11545	
72 11545 CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		COFIELD, JOHN LOUIS		DECEMBER 2, 1972 5:10 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  ST. AGNES HOSPITAL			A. STATE MARYLAND		
			B. COUNTY		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 701 YALE AVENUE 21229		
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-9-04	9. AGE (In years last birthday) 68
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED HOUSE PAINTER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) ALABAMA	
13. FATHER'S NAME JOHN RICHARD COFIELD			14. MOTHER'S MAIDEN NAME DOLLY (LLOYD)		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES NO WAR		16. SOCIAL SECURITY NO. 218-18-7510		17. INFORMANT ST. AGNES RECORDS-BALTO MD 21229	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  CAUSE OF DEATH I 410.9 Anterior Exhilation acute myocardial infarct			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from DECEMBER 2, 1972 to DECEMBER 2, 1972, that (I) (we) last saw the deceased alive on DECEMBER 2, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Eduardo G. Romero, M.D.				23B. DATE SIGNED 12-2-72	
23C. PHYSICIAN'S NAME (Type) EDUARDO ROMERO, M.D.				23D. ADDRESS ST. AGNES HOSPITAL CATON & WILKENS AVE	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-6-72		24C. NAME OF CEMETERY OR CREMATORY LOUDON PARK CEMETERY	
24D. LOCATION BALTIMORE		24E. LOCATION MARYLAND			
25A. DATE REC'D BY HEALTH DEPT. DEC 6 1972		25B. NAME OF REGISTRAR Audrey H. Houston		25C. FUNERAL DIRECTOR HUBBARD, FUNERAL HOME 4107 WILKENS AVE. 21229	



24-524'

100

1. *Chlorophyll a* and *Chlorophyll b* were determined by the method of Lichtenthaler and Whistler (1973).

入食。



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 11546</u>	
72 11546 CERTIFICATE OF DEATH				STATE OF MARYLAND-DMH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <del>XXXXXXXXXX</del> SHETTERLEY, ROBERT O.		2. DATE AND HOUR OF DEATH 12 1 72 6:20 PM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD, B. COUNTY		2582	
FULL NAME OF HOSPITAL OR INSTITUTION ST AGNES HOSPITAL BALTIMORE, MD.		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 1711 CASADEL AVE.			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4 21 05	9. AGE (In years last birthday) 67	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED/TRK DRIVER.		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) OHIO	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME L. FRANK SHETTERLEY		14. MOTHER'S MAIDEN NAME N. IVY (CHESTANT)	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES		16. SOCIAL SECURITY NO. 2452 12 3823		17. INFORMANT Mrs. Vera P. Shetterley, 1711 Casadel Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE hepatic Coma. DUE TO, OR AS A CONSEQUENCE OF: (B) Liver cirrhosis DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 10-23-72 to 12-1-72, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 12-1-72 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.					
23A. SIGNATURE Fereydoun Dehkhareghani				23B. DATE SIGNED 12-1-72	
23C. PHYSICIAN'S NAME (Type) FEREYDOUN DEHKHAREGHANI MD		23D. ADDRESS ST AGNES HOSPITAL, BALTO., MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 12-5-72		24C. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE MEMORIAL PARK	
24D. LOCATION (City, town, or county) (State) HOWARD COUNTY MARYLAND		25A. DATE REC'D BY HEALTH DEPT. DEC 6 1972			
25B. NAME OF REGISTRAR Sidney Johnston		25C. FUNERAL DIRECTOR HUBBARD FUNERAL HOME 4107 WILKENS AVE. 21229			



72 11547

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 11547

BIRTH NO.

STATE OF MARYLAND-DEMH

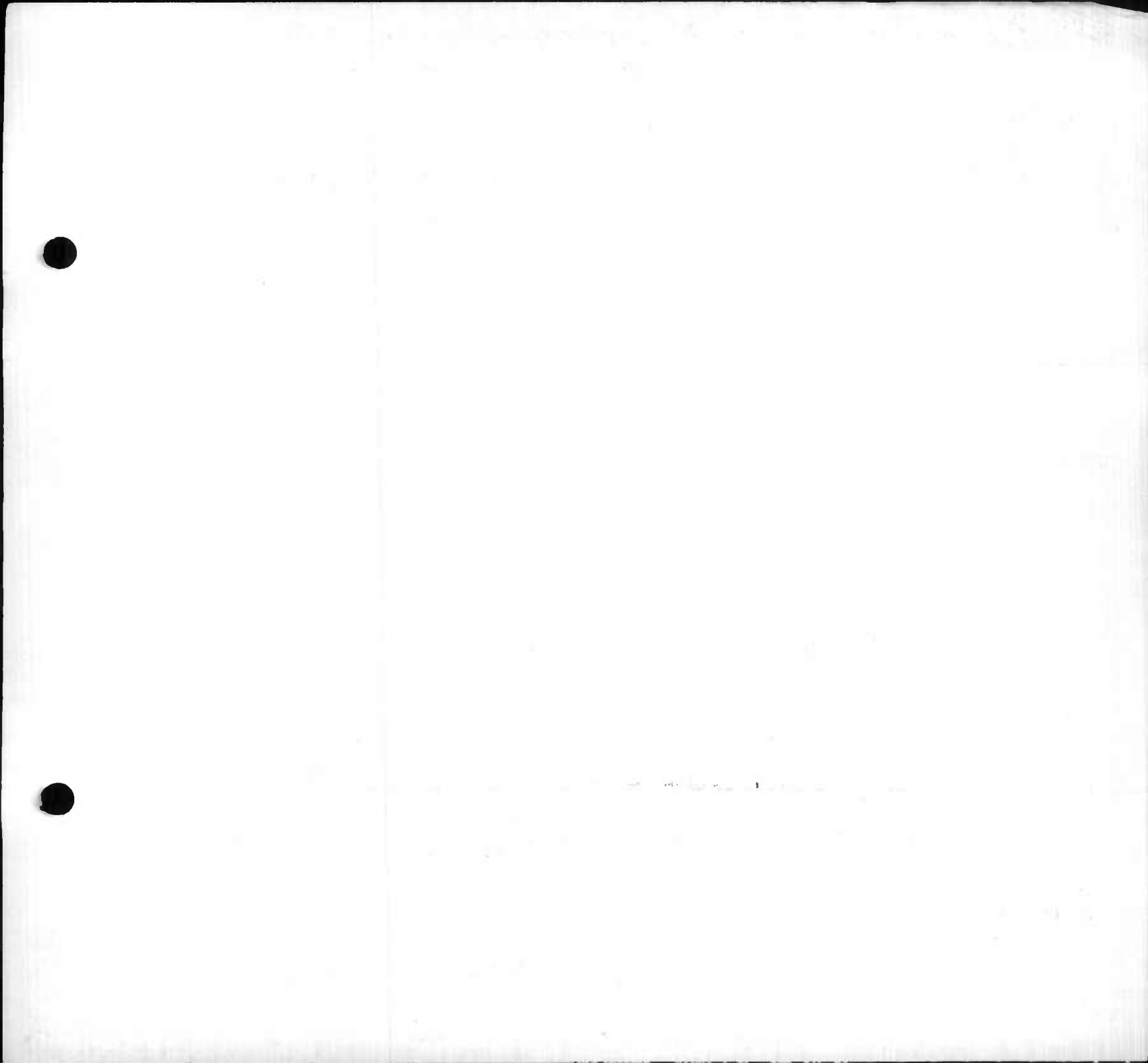
1. NAME OF DECEASED (Type or Print) <b>MICHAEL WHEELER</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>St. Agnes Hospital (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour M. <b>12 3 1972 10:15p</b>	
6. SEX <b>male</b>		7. RACE <b>white</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>BALTO</b>	
9. DATE OF BIRTH <b>Jan 21, 1961</b>		10. AGE (in years lost birthday) <b>11</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Albert P. Wheeler</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME <b>Leister</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, give year or dates of service) <b>No</b>	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS <b>Albert Wheeler 702 Wedeman Ave 21090</b>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>home</b>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>702 Weedman Avenue</b>		22D. TIME OF INJURY (APPROX.) <b>12-3-72</b>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Subj. got entangled in drapes in opening between 2 rooms</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>12-4-72</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/6/72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Lorraine Park Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 6 1972</b>		25B. NAME OF REGISTRAR <b>Sidney Indurmont</b>	
25C. FUNERAL DIRECTOR ADDRESS <b>Alan Seitz, Jr. 3818 Roland Ave.</b>			

12-15-1972 - Completion of cause of death on a pending medical examiner death certificate-  
Russell S. Fisher, M.D. HS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-652 1		72 11548		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 11548	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>ARMIGER, Cecil I.</b>				2. DATE AND HOUR OF DEATH <b>12/4/72 8:28 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>38 University of Md. Hospital</b>						A. STATE <b>Md.</b>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)						B. COUNTY <b>AA</b>			
						C. CITY OR TOWN <b>Arnold</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
						E. STREET AND NUMBER <b>937 LAKE Drive</b>			
5. SEX <b>M.</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-5-07</b>	9. AGE (In years last birthday) <b>64</b>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Furn. Operator</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Gen. Elec. Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Cecil Armiger</b>						14. MOTHER'S MARDEN NAME <b>Helen ?</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>214-12-8822</b>		17. INFORMANT <b>Charlotte Armiger</b>			
18. CAUSE OF DEATH						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)						(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Carcinoma Esophagus</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last						(B) DUE TO, OR AS A CONSEQUENCE OF:			
						(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Liver Cirrhosis</b>									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>J. V. Iglesias M.D.</b>				23B. DATE SIGNED <b>12/4/72</b>		23C. PHYSICIAN'S NAME (Type) <b>Jose V. Iglesias M.D.</b>			
23D. ADDRESS <b>University of Md. Hospital Balto.</b>									
24A. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>12/6/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>London Park Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 6 1972</b>		25B. NAME OF REGISTRAR <b>Sidney H. Horton</b>		25C. FUNERAL DIRECTOR <b>John J. McManis</b>		25D. ADDRESS <b>2122 St.</b>			





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 11549

BIRTH NO.		STATE OF MARYLAND - DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <i>Ruth</i> NAOMI MITCHELL		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Month Day Year		Hour	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <i>00</i> 3825 8th St.		3. DATE PRONOUNCED DEAD Month Day Year 12 3 1972		Hour 11:09a	
6. SEX female		7. RACE white		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH		10. AGE (In years last birthday) 64		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Bruce Mallone		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
15. MOTHER'S MAIDEN NAME Sally?		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 276 01 0665	
18. INFORMANT William H. Mitchell		19. CAUSE OF DEATH Arteriosclerotic cardiovascular disease		20. ADDRESS 3825 8th Street 21225	
21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		22. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		23. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
24. DATE OF OPERATION		25. CONDITION FOR WHICH OPERATION WAS PERFORMED		26. AUTOPSY? (Yes or No) no	
27. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		28. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		29. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
30. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		31. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		32. HOW DID INJURY OCCUR?	
<p>I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p> <p>ACTUAL SIGNATURE: <i>Ronald N. Kornblum</i> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/></p> <p>EXAMINER'S NAME (Type): Ronald N. Kornblum, M.D. Deputy Chief Medical Examiner ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></p> <p>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: 12-4-72</p>					
33. BURIAL CREMATION, REMOVAL (Specify) Burial		34. DATE 12/7/92		35. NAME OF CEMETERY or CREMATORY Glen Haven Cemetery	
36. DATE REC'D BY HEALTH DEPT. DEC 6 1972		37. NAME OF REGISTRAR Sidney H. Keston		38. FUNERAL DIRECTOR McGally	
39. LOCATION (City, town, or county) Glen Burnie Md. 21061		40. ADDRESS 237 Patapsco Ave Balto 21225			





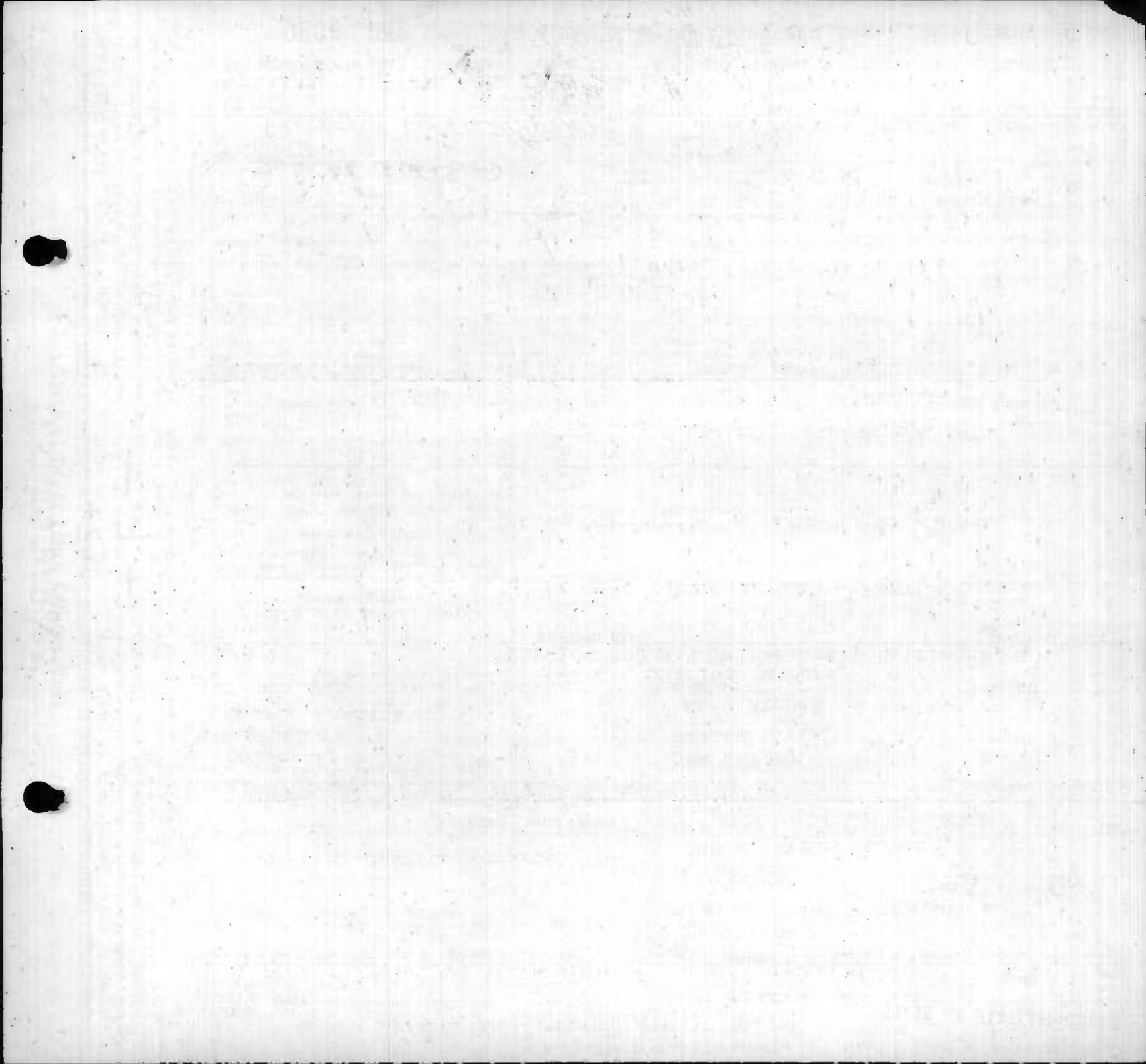
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
72 11550 CERTIFICATE OF DEATH

REG. NO. 72 11550  
STATE OF MARYLAND-DHMH

BIRTH NO. 72 11550		DATE AND HOUR OF DEATH DECEMBER 1 12:40 P.M.	
1. NAME OF DECEASED (Type or Print) <b>PUMPHREY, HEBEDINA</b>		2. DATE AND HOUR OF DEATH	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>33 The Johns Hopkins Hospital</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2609</b>	
5. SEX <b>Female</b> 6. RACE <b>Cauc.</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/07/10</b> 9. AGE (In years last birthday) <b>62</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>	
13. FATHER'S NAME <b>Conrad Ansmink</b>		14. MOTHER'S MAIDEN NAME <b>Mary Stokes</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-10-5390</b>	
17. INFORMANT <b>Charles Pumphrey</b>		ADDRESS <b>3247 Pelham Ave., Baltimore, Md.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>410.94-320.8</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>ACUTE MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF: <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. DATE OF OPERATION <b>0</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At <input type="checkbox"/> Work	
21F. HOW DID INJURY OCCUR?		21G. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22. I certify that (I) (this hospital) attended the deceased from <b>11/27</b> 19 <b>72</b> to <b>12/1</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>12/1</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Frederick L. Ferriss MD</b>		23B. DATE SIGNED <b>12/1/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>FREDERICK L. FERRISS MD</b>		23D. ADDRESS <b>JOHNS HOPKINS HOSPITAL 60 N. BROADWAY</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-4-72</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 6 1972</b>		25B. NAME OF REGISTRAR <b>Sidney W. Houston</b>	
25C. FUNERAL DIRECTOR <b>Nicholas T. Matthews</b>		ADDRESS <b>3021 Eastern Ave., Baltimore, Md.</b>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 11551

BIRTH NO.

STATE OF MARYLAND-DEATH

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>KAREN STAYLOR</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>33 JOHNS HOPKINS HOSPITAL</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>December 2, 1972 3:04 P.M.</b>	
6. SEX <b>Female</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>Nov. 8, 1955</b>		10. AGE (in years last birthday) <b>17</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William V. Staylor</b>		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2653</b>	
15. MOTHER'S MAIDEN NAME <b>Delores O'Dell</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
17. SOCIAL SECURITY NO. <b>216-68-1955</b>		18. INFORMANT <b>Mr. William Staylor 8039 Midhaven Rd. Balto.</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Craniocerebral Injuries</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
22. (C) DUE TO, OR AS A CONSEQUENCE OF:			
23. MEDICAL CERTIFICATION I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		24. AUTOPSY? (Yes or No) <b>no</b>	
25. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		26. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>	
27. TIME (Month) (Day) (Year) (Hour) (Approx.) <b>12-2-72 2:05 P. m.</b>		28. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
29. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>656 Ft. West of Elwood Street in 3300 Block Sinclair Lane</b>		30. HOW DID INJURY OCCUR? (loss control) <b>Passenger in auto-auto collision</b>	
31. ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>		32. DATE SIGNED <b>12/3/72</b>	
33. DEPUTY CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
34. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		35. DATE <b>12/6/72</b>	
36. NAME OF CEMETERY or CREMATORY <b>Oaklawn Cemetery</b>		37. LOCATION (City, town, or county) (State) <b>Eastern Avenue Balto. Md.</b>	
38. DATE REC'D BY HEALTH DEPT. <b>DEC 6 1972</b>		39. NAME OF REGISTRAR <b>Sidney Johnston</b>	
40. FUNERAL DIRECTOR <b>Lassahn, Funeral Home</b>		41. ADDRESS <b>7401 Belair Rd. Balto.</b>	

INNOVATIVE

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 11552

BIRTH NO.

STATE OF MARYLAND-DEMD

1. NAME OF DECEASED  
(Type or Print)

ROBERT E. BURDEKIN

2. DATE  
OF DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(If not in hospital or institution, give street  
address or location)

31 CITY HOSPITAL

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

December 1, 1972

9:59 A.

M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

2757

6. SEX

Male

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

Aug. 12, 1918

10. AGE (In years  
last birthday)

54

If Under 1 Yr. If Under 24 Hrs.

Months

Days

Hours

Min.

E. STREET AND NUMBER

2910 Northern Parkway

11. BIRTHPLACE (State or foreign country)

New York

12. CITIZEN OF

U.S.A.

13. FATHER'S NAME

Robert F. Burdekin

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Import Mgr.

14B. KIND OF BUSINESS OR INDUSTRY

Furnace Withey Co.

15. MOTHER'S MAIDEN NAME

Mabel

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WWII &amp; Korea

17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

Mary Agnes Burdiken - 2910 Northern Pky. - 21214

19.

4124 I

CAUSE OF DEATH

Arteriosclerotic cardiovascular disease

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Ronald N. Kornblum, M.D.

Deputy

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/2/72

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

12-5-72

24C. NAME of CEMETERY or CREMATORY

Gardens of Faith Cemetery

24D. LOCATION (City, town, or county)

Balto. Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

DEC 6 1972

25B. NAME OF REGISTRAR

Audrey Indestrom

25C. FUNERAL DIRECTOR

John C. Miller Inc-6415 Belair Road-21206

ADDRESS



100-10440-180110

100-10440-180110

100-10440-180110

100-10440-180110

100-10440-180110

100-10440-180110

100-10440-180110

100-10440-180110

100-10440-180110

100-10440-180110

100-10440-180110

100-10440-180110

100-10440-180110

100-10440-180110

100-10440-180110

100-10440-180110



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 11553		REG. NO. 72 11553	
72 11553				STATE OF MARYLAND-DEME		X	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
		Stella M. Dragier		December 2, 1972		2 35 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
Belaire - House in the Pines 90 5837 Belair Road				Maryland Baltimore County 5300			
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
Female		Caucasian		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Sept 15, 1888	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday)		11. BIRTHPLACE (State or foreign country)	
housewife		-----		84		Baltimore, Maryland	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Michael Rozanski				Rosalie ( unknown )			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
no		218-58-5174		Helen Pencek		1735 Stengel Aven 21222	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				months			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinomatosis			
ANTECEDENT CAUSES				(B) Adenocarcinoma of the sigmoid colon ?			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) -----			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				no			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 11/4/1972 to 12/2/1972, that (I) (we) lost the deceased alive on 11/30/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Albert B. Bradley				12/4/72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Albert Bradley M.D.				Belair Road & Woodlea Aven Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
burial		Dec. 6, 1972		Holy Cross Cem		Baltimore Maryland, Dundalk	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
DEC 6 1972		Sidney H. Heston		Dippel Brothers, Inc		7110 Belair Rd. 06	

DECEMBER 1940

RECEIVED

NOV 1940

1940

1940

1940

1940

1940

1940

1940

1940

1940

1940

1940

1940

1940

1940

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND - <del>DEATH</del>		BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO. 72 11554		CERTIFICATE OF DEATH	
REG. NO. 72 11554		X	
1. NAME OF DECEASED (Type or Print) <b>Nichols, Ethel</b>		2. DATE AND HOUR OF DEATH 12/4/72 7:43 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md</b> B. COUNTY <b>Balto.</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>4940 Eastern Avenue Baltimore, Maryland</b>		C. CITY OR TOWN <b>Dundalk</b>	D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
E. STREET AND NUMBER <b>600 Willow Spring Rd 21222</b>			
5. SEX <b>Female</b>	6. RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/3/19</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>cook</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) <b>53</b>
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Archie Forbes</b>		14. MOTHER'S MAIDEN NAME <b>Gertrude</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-07-43 23</b>	
17. INFORMANT <b>BCH: RECORDS</b>		ADDRESS <b>4940 Eastern Avenue Baltimore, Maryland 21224</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>4/10/91</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cardiorespiratory arrest</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Pulmonary edema</b> (C) <b>MI (possible)</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>20 minutes</b> <b>40 minutes</b> <b>7 days</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>None</b>			
19A. DATE OF OPERATION <b>2</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>None</b>	20A. AUTOPSY? (Yes or No) <b>Yes</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>No</b>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>None</b>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>None</b>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <b>None</b>	21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? <b>No injury</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>12/4/72</b> 19 <b>72</b> to <b>12/4</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>12/4</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Robert M. Duda</b>		23B. DATE SIGNED <b>12/5/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Richard C. Sullivan</b>		23D. ADDRESS <b>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</b>	
24A. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>11/8/72</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 6 1972</b>	25B. NAME OF REGISTRAR <b>Franklin</b>	25C. FUNERAL DIRECTOR <b>John J. Duda</b>	
		ADDRESS <b>7922 Wise Ave. Dundalk, Md.</b>	

1882-1883

1882-1883  
1882-1883



1882-1883  
1882-1883



1882-1883  
1882-1883

1882-1883  
1882-1883

1882-1883

1882-1883  
1882-1883

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 11555	
CERTIFICATE OF DEATH				REG. NO. _____	
BIRTH NO. 72 11555		1. NAME OF DECEASED (Type or Print) MARY YOUNGBLOOD		2. DATE AND HOUR OF DEATH 12-2-72 4:00 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) MARYLAND GENERAL HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 1602 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1510 MOSHER ST 21217		
5. SEX F	6. RACE B	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/15/1933	9. AGE (In years last birthday) 33	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VA.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Alexander White			
14. MOTHER'S MAIDEN NAME Fannie Metley		15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. 216-20-4494		17. INFORMANT Albert White 1400 McCulloch St (Brother) Balt 21217			
18. 5-71.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE Upper GI Bleed DUE TO, OR AS A CONSEQUENCE OF:  (B) <del>Peptic ulcer disease</del> Esophageal varices DUE TO, OR AS A CONSEQUENCE OF: Laennec's Cirrhosis (C) _____  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 days		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (it) (this hospital) attended the deceased from 11/24/1972 to 12/2/72 that (I) (we) last saw the deceased alive on 12/2/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Roger Monahan MD			23B. DATE SIGNED 12/2/72		23C. PHYSICIAN'S NAME (Type) MAMAH
23D. ADDRESS Md-Genl. Hosp. Balt Md			24A. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 12/6/72			24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery		
24D. LOCATION (City, town, or county) (State) Westport, Maryland			25A. DATE REC'D BY HEALTH DEPT. 1		
25B. NAME OF REGISTRAR 720006			25C. FUNERAL DIRECTOR Charles A. Rice 1300 N. Eutaw Place		



UNITED STATES DEPARTMENT OF AGRICULTURE



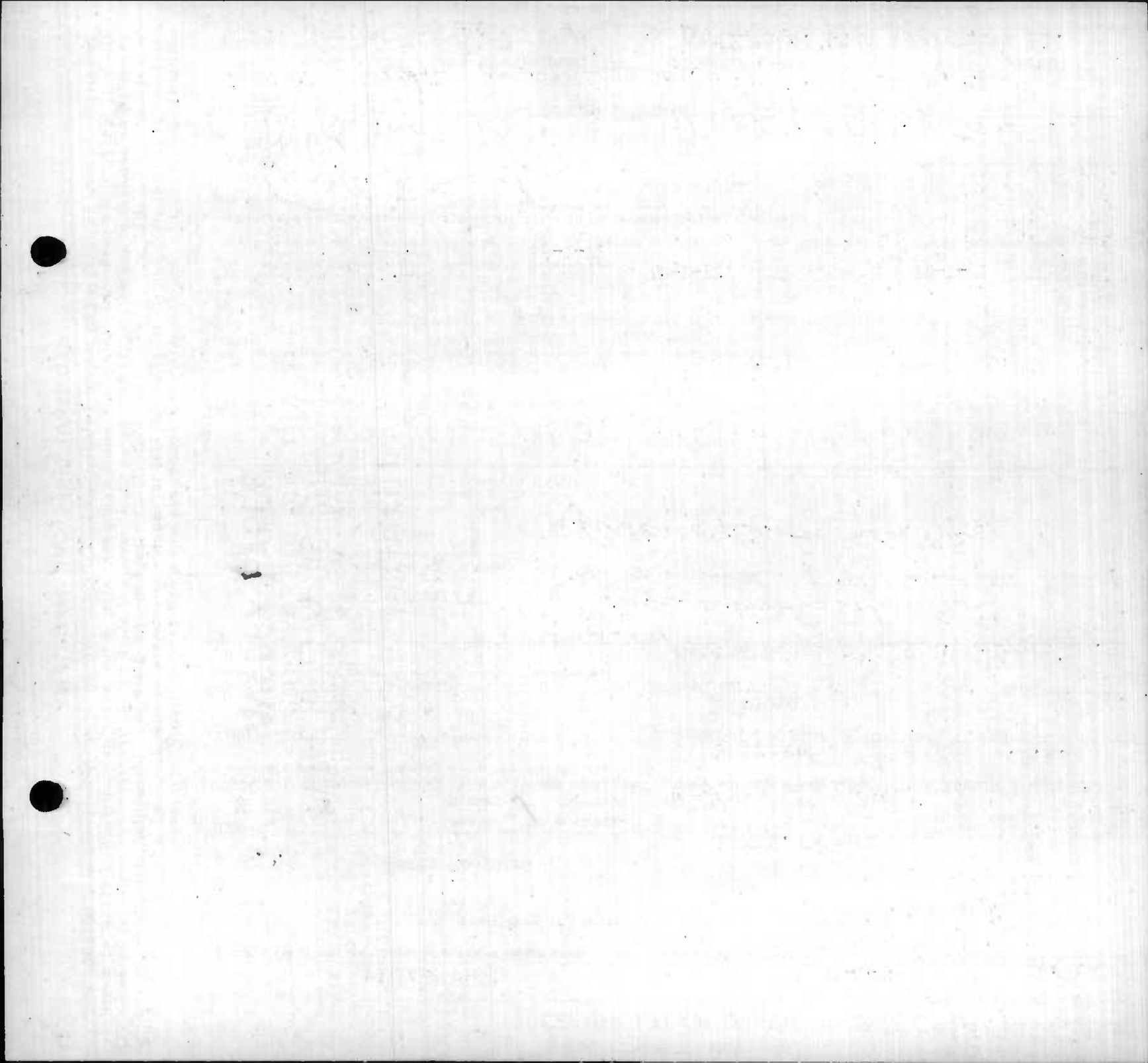


**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 11556	
CERTIFICATE OF DEATH				REG. NO. 72 11556	
BIRTH NO. 72 11556			1. NAME OF DECEASED (Type or Print) <b>Millard Fitch</b>		
2. DATE AND HOUR OF DEATH <b>12-1-72 11:50 A M.</b>			3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>37 Mercy Hospital</b>		
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md</b> B. COUNTY <b>1101</b>			5. SEX <b>M</b> 6. RACE <b>W</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
C. CITY OR TOWN <b>Balto</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			8. DATE OF BIRTH <b>4/13/01</b> 9. AGE (In years last birthday) <b>71</b>		
E. STREET AND NUMBER <b>1209 N. Calvert St.</b>			10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Unknown</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Martha Jenkins 1209 N. Calvert St.</b>
18. <b>410.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Infarction</b> CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Arteriosclerotic heart D.</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
<b>II</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12-1-72</b> 19 to <b>12-1-72</b> 19, that (I) (we) last saw the deceased alive on <b>12-1-72</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Dr Kwang Lee</b> DEGREE				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>Dr Kwang Lee</b> DEGREE				23D. ADDRESS <b>Mercy Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/5/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Meadow Ridge Cem.</b>	
24D. LOCATION <b>Elkridge, Md</b>		25A. DATE REC'D BY HEALTH DEPT. 25B. NAME OF REGISTRAR <b>Charles A Rice</b> 25C. FUNERAL DIRECTOR ADDRESS <b>1300 Eutaw Pl.</b>			





14-6201

72 11557

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO.

72 11557

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

HARRIS, Russell

2. DATE AND HOUR OF DEATH

December 2, 1972 6:15 pm

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

46

Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Maryland

1509

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

3909 Bateman Avenue

5. SEX

MALE

6. RACE

N

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

8-8-04

9. AGE (In years  
last birthday)

68

10. Under 1 Yr. 11. Under 24 Hrs.

Months Days

Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Edward T. Harris

14. MOTHER'S MAIDEN NAME

Ella Perry

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

214-07-8983

17. INFORMANT

Edgar Harris 617 Washington St. Cambridge, Md.

ADDRESS

18. 436.01

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Coronary - Vascular Accident

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

2 days

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Hypertension

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Nov. 30th 1972 to Dec. 2nd 1972  
that (I) (we) lost saw the deceased alive on Dec. 2nd 1972 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Famuyiwa, O.O.O. M.D.

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☐

23B. DATE SIGNED

Dec. 2nd 1972

23C. PHYSICIAN'S  
NAME (Type)

FAMUYIWA, O.O.O. M.D.

23D. ADDRESS

LUTHERAN HOSPITAL OF MARYLAND  
730 BATHURSTON ST. BALTO.24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

12/7/72

24C. NAME OF CEMETERY or CREMATORY

Bethel AME Church Cem.

24D. LOCATION

(City, town, or county)

Cambridge, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

1972000

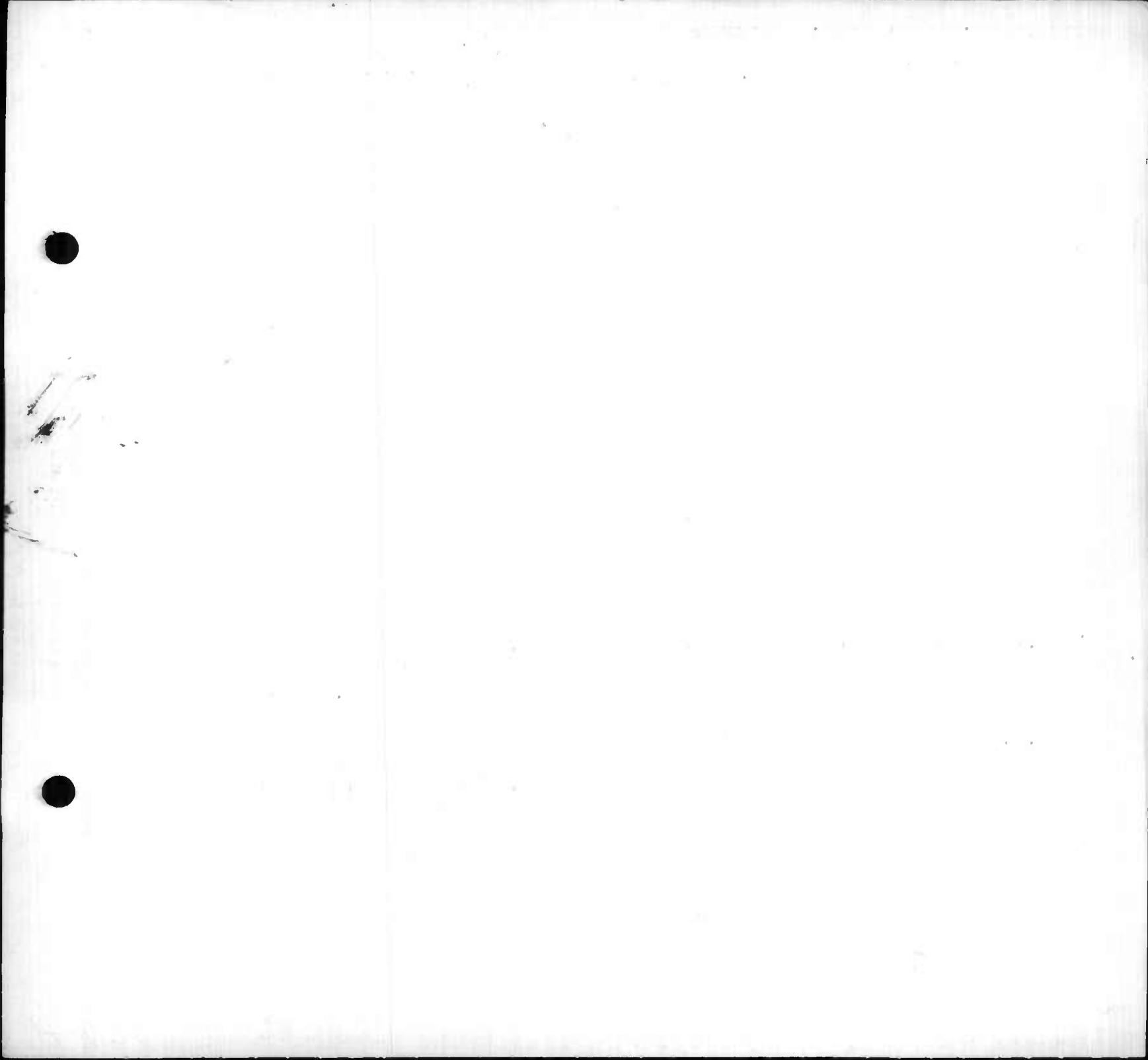
25C. FUNERAL DIRECTOR

Charles A. Rice 1300 N. Eutaw Place

ADDRESS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT



W-425 1

STATE OF MARYLAND - DEPT.

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO.

72 11558

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Henry Wilson

2. DATE AND HOUR OF DEATH

11/24/72 14 30 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

38 Univer. of Md. Hosp.

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

Md.

Balto.

1204

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

447 E. 22<sup>nd</sup> St.

21218

5. SEX

M

6. RACE

N

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

7/4/1904

9. AGE (In years last birthday)

67

If Under 1 Yr.

Months: Days

If Under 24 Hrs.

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

D. O. A.

10B. KIND OF BUSINESS OR INDUSTRY

Sh. worker

11. BIRTHPLACE (State or foreign country)

Ind.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Henry Wilson

14. MOTHER'S MAIDEN NAME

Adele Wilson

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

218-090693

17. INFORMANT

Adele Wilson

ADDRESS

3402 Fairview Ave.

18.

15791

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

C.A. of Pancreas

with metastases to

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Liver

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

O

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Conrad E. Nagle, M.D.

DEGREE

Attending Phys. ☐Med. Director ☐Staff Phys. ☐

23B. DATE SIGNED

11/24/72

23C. PHYSICIAN'S NAME (Type)

CONRAD E. NAGLE M.D.

DEGREE

23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

11/29/72

24C. NAME OF CEMETERY OR CREMATORY

Mt. Z. on Annapolis Heights

24D. LOCATION (City, town, or county)

A.A. County Md.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

DEC 6 1972

25B. NAME OF REGISTRAR

Audrey H. H. H.

25C. FUNERAL DIRECTOR

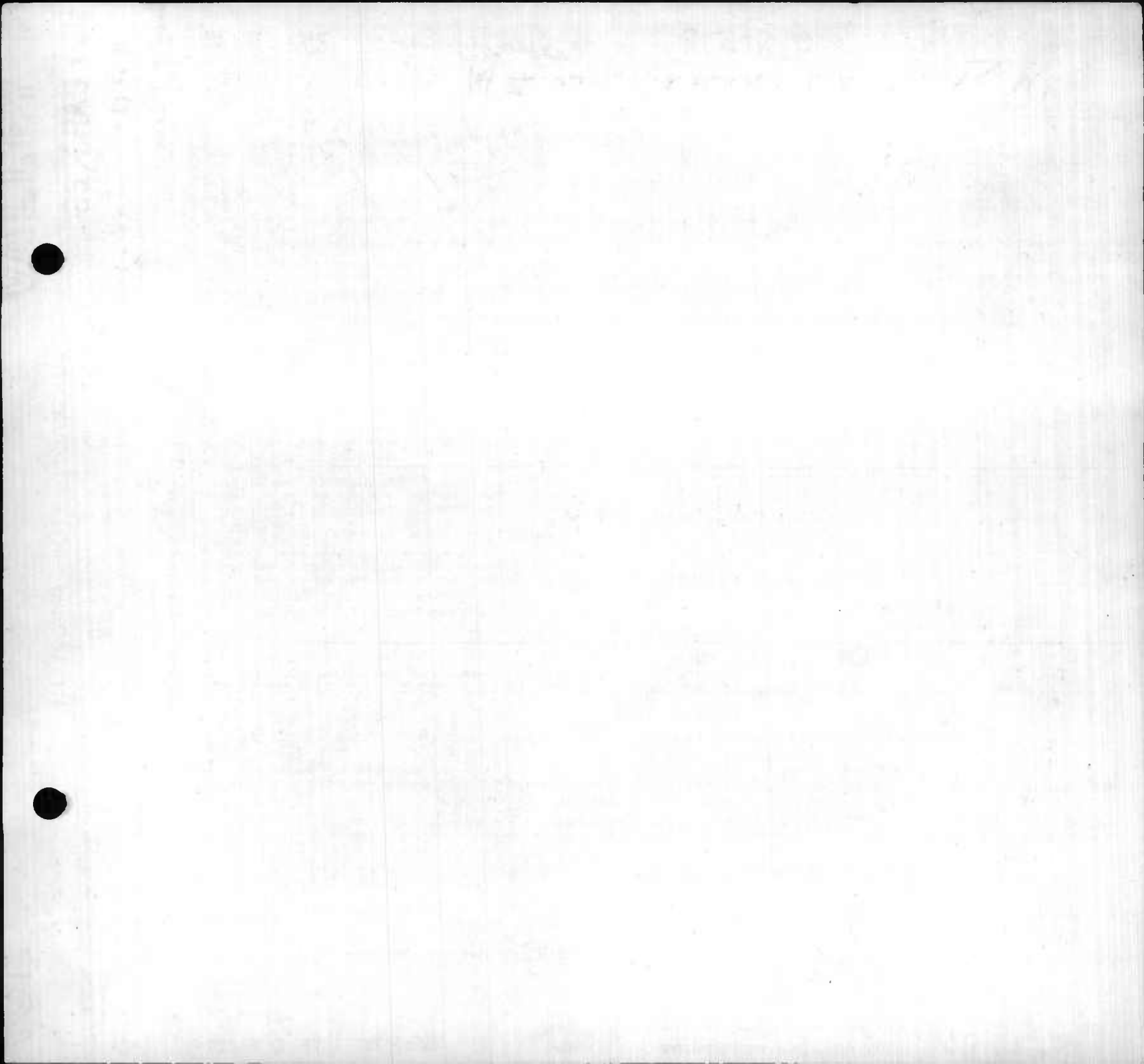
Gus S. S.

ADDRESS

1712 W. North Ave

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 11559

BIRTH NO.

STATE OF MARYLAND - DEPT

1. NAME OF DECEASED  
(Type or Print)

ARTHUR J. HEPBURN

2. DATE OF DEATH  
Known ☐ Estimated ☐ Month Day Year Hour M.4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

5 W. Biddle St. Apt. #1

3. DATE PRONOUNCED DEAD Month Day Year Hour M.  
12 3 1972 11:45p M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Md. B. COUNTY Anne Arundel

6. SEX

male

7. RACE

white

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

21056

D. INSIDE CITY LIMITS?

YES ☐ NO ☒

Gibson Island

9. DATE OF BIRTH

Jan. 19, 1932

10. AGE (In years last birthday)

40

If Under 1 Yr. II Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

Rural

5200

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Arthur J. Hepburn, Jr.

14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Sales

14B. KIND OF BUSINESS OR INDUSTRY

General

15. MOTHER'S MAIDEN NAME

Eleanor Macgill

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

Yes

17. SOCIAL SECURITY NO.

213-32-2251

18. INFORMANT

ADDRESS

Mrs. W. Bladen Lowndes, Gibson Island, Md.

19.

571.81

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

Fatty infiltration of liver

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-4-72

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

12/6/72

24C. NAME of CEMETERY or CREMATORY

Rose Hill

24D. LOCATION (City, town, or county)

Cumberland

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT

DEC 6 1972

25B. NAME OF REGISTRAR

Audrey H. Boston

25C. FUNERAL DIRECTOR

H.W. Jenkins &amp; Sons Co. 4905 York Rd.

ADDRESS

Balto. Md. 21212

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

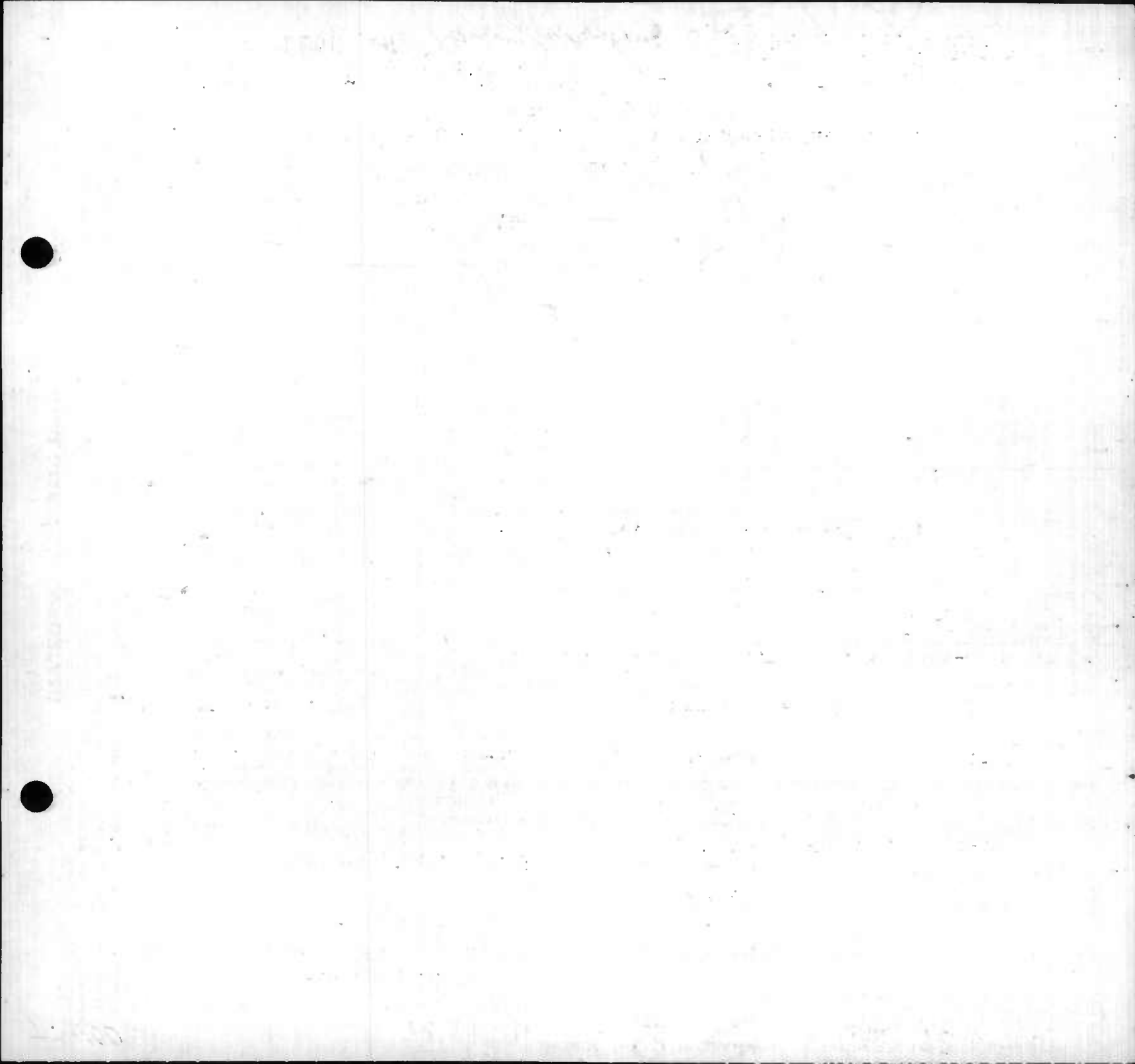
1000



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 11560	
72 11560				STATE OF MARYLAND - DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Phyllis C. Teano		2. DATE AND HOUR OF DEATH 12-2-72 11.45 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  00 Lombardy Apts. Apt. 2C			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. 8. COUNTY 1201 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 220 Stoney Run Rd. 21210		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-20-10	9. AGE (In years last birthday) 62	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Office Work		10B. KIND OF BUSINESS OR INDUSTRY Govt.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Vincent R. Teano		14. MOTHER'S MAIDEN NAME Emma Rankle	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 215-10-1743		17. INFORMANT ADDRESS Miss Margaret R. Spellissy Same	
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) no 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from July 24 1972 to Dec. 2 - 1972, that (I) last saw the deceased alive on Dec. 2 1972 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE Earl L. Chambers M.D. 23B. DATE SIGNED 12/4/72 - 23C. PHYSICIAN'S NAME (Type) Earl Chambers, M. D. 23D. ADDRESS 100 W. Cold Spring La. 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 12-5-72 24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery 24D. LOCATION Baltimore, Maryland 25A. DATE REC'D BY HEALTH DEPT. DEC 6 1972 25B. NAME OF REGISTRAR Sidney H. Heston 25C. FUNERAL DIRECTOR ADDRESS Henry W. Jenkins Sons 4905 York Rd. Baltimore, Md. 21212					



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
72 11561 CERTIFICATE OF DEATH 72 11561									
REG. NO. MARYLAND DEPT. OF HEALTH & MENTAL HYGIENE									
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>EVELYN L. MADEN</b>							
		2. DATE AND HOUR OF DEATH <b>DEC 5, 1972 9:06 P. M.</b>							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>906</b>				
FULL NAME OF HOSPITAL OR INSTITUTION <b>33 The Johns Hopkins Hospital</b>					C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					E. STREET AND NUMBER <b>2024 E. 31st Street 21218</b>				
5. SEX <b>Female</b>	6. RACE <b>Cauc.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/7/17</b>	9. AGE (In years last birthday) <b>55</b>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret'd Kitchen Supervisor Johns Hopkins</b>				11. BIRTHPLACE (State or foreign country) <b>Tenn.</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>James Norton</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Cook</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>408-24-7104</b>		17. INFORMANT <b>Mr. Charles D. Maden</b>		ADDRESS <b>Same</b>	
18. <b>174X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b>									
(A) IMMEDIATE CAUSE <b>SEPTICEMIA</b> DUE TO, OR AS A CONSEQUENCE OF: <b>1 DAY</b>									
(B) <b>INTESTINAL OBSTRUCTION</b> DUE TO, OR AS A CONSEQUENCE OF: <b>2 DAYS</b>									
(C) <b>METASTATIC CARCINOMA BREAST</b> DUE TO, OR AS A CONSEQUENCE OF: <b>2 YEARS</b>									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>METASTATIC BRAIN DAMAGE</b>									
19A. DATE OF OPERATION <b>NONE</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (If (this hospital) attended the deceased from <b>12/5/72</b> 19 to <b>12/5</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>12/5</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Leslie Pearlstein MD</b>								23B. DATE SIGNED <b>Dec 5, 1972</b>	
23C. PHYSICIAN'S NAME (Type) <b>LESLIE PEARLSTEIN MD</b>				23D. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-9-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Moreland Memorial Park Balto. Co. Md.</b>		24D. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 6 1972</b>		25B. NAME OF REGISTRAR <b>Sidney Johnston</b>		25C. FUNERAL DIRECTOR <b>H. W. Jenkins &amp; Sons Co.</b>		ADDRESS <b>4905 York Road Balto.; Md. 21212</b>			

UNITED STATES DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

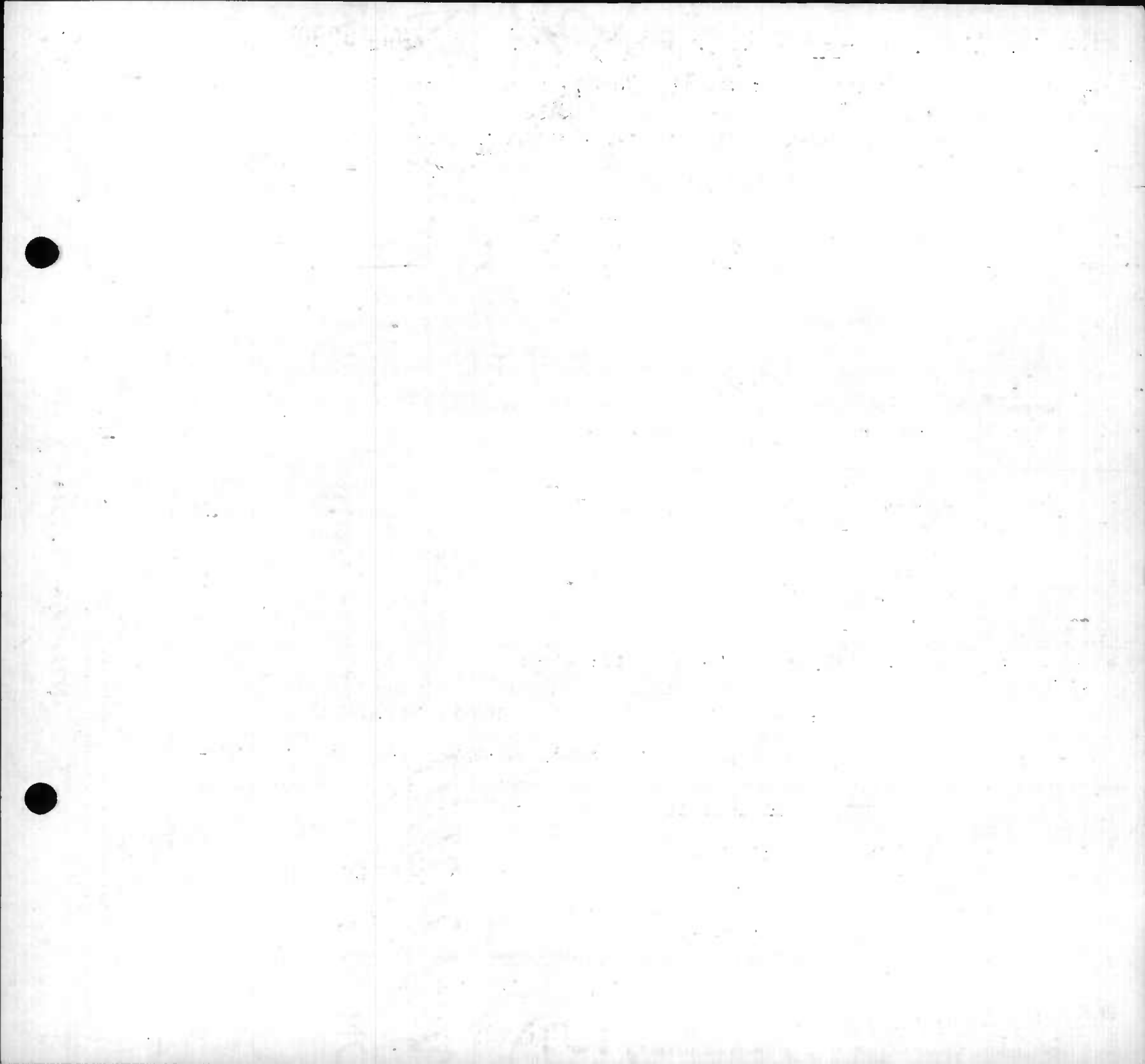
WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 11562	
72 11562				STATE OF MARYLAND - DEPT.	
BIRTH NO.			1. NAME OF DECEASED (Type or Print)		
			Catherine M. Constant		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
00 1306 Winston Avenue			Maryland		
5. SEX F			6. RACE W		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 11-10-1894		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			9. AGE (In years last birthday) 78		
Ret. Pvt. Secretary Equitable Trust Co.			11. BIRTHPLACE (State or foreign country) Baltimore		
13. FATHER'S NAME Patrick J. Maquire			12. CITIZEN OF WHAT COUNTRY? USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 215-07-6116		
17. INFORMANT Mrs. Catherine Christ 8218 Bear Creek Drive			ADDRESS		
18. CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial infarction 2 hr.		
ANTECEDENT CAUSES			(B) Hypertensive arteriosclerosis 12+ yrs. DUE TO, OR AS A CONSEQUENCE OF: Heart disease		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			Recurrent G.I. bleeding - Listeria hernia 8 yrs.		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
G			20A. AUTOPSY (Yes or No) No		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> At Work			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from Jan 1960 to Dec 6 1972, that (I) (we) last saw the deceased alive on Nov 2 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Frederick J. Vollmer M.D.			23B. DATE SIGNED 12-6-72		
23C. PHYSICIAN'S NAME (Type) Frederick J. Vollmer M. D.			23D. ADDRESS 6100 York Road		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 12-9-72		
24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery			24D. LOCATION (City, town, or county) (State) Balto. Md.		
25A. DATE REC'D BY HEALTH DEPT. DEC 6 1972			25B. NAME OF REGISTRAR Sidney H. Jenkins		
25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co.			ADDRESS 4905 York Road Balto., Md. 21212		





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 11563 CERTIFICATE OF DEATH				REG. NO. 72 11563	
BIRTH NO.				STATE OF MARYLAND-DHMH	
1. NAME OF DECEASED (Type or Print) <b>KIRK, EUGENIA D.</b>			2. DATE AND HOUR OF DEATH <b>6:40 PM 12.4.72</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>Anne Arundel</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>South Baltimore Funeral Hospital Baltimore, MD 21250</b>			C. CITY OR TOWN <b>Glen Burnie</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <b>Female</b> 6. RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>9.4.1914</b>		9. AGE (In years last birthday) <b>58</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pvt. Secretary</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>A.A. Co Pub. Works</b>		11. BIRTHPLACE (State or foreign country) <b>MD. Germany</b>
12. CITIZEN OF WHAT COUNTRY? <b>America.</b>			13. FATHER'S NAME <b>JOHN DREYER</b>		
14. MOTHER'S MAIDEN NAME <b>ELIZABETH, Anholt</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>213/03/8782</b>			17. INFORMANT <b>Pauline Fubb (sister) Rt 9, Box 90A, MD</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>1538 I</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Carcinomatous</b> (B) <b>Carcinoma of Colon</b> (C) <b>2 yrs.</b>		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>			OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		
19A. DATE OF OPERATION <b>12.4.72</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NO</b>		
20A. AUTOPSY? (Yes or No) <b>NO</b>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <b>NO</b>		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>NO</b>			21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>12.4.72</b>		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR? <b>NO</b>		
22. I certify that (I) (this hospital) attended the deceased from <b>11.29.1972</b> to <b>12.4.1972</b> , that (I) (we) last saw the deceased alive on <b>12.4.1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>M. V. KHATTAK MD</b>			23B. DATE SIGNED <b>12.4.72</b>		
23C. PHYSICIAN'S NAME (Type) <b>M. V. KHATTAK MD</b>			23D. ADDRESS <b>South Baltimore Genl. Hospital</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/7/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem'l Park</b>	
24D. LOCATION <b>Elkridge RFD, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 6 1972</b>			
25B. NAME OF REGISTRAR <b>Andrew H. Hoston</b>		25C. FUNERAL DIRECTOR <b>Singleton Funeral Home, Glen Burnie, Md.</b>			



DECEMBER

1914

1914

1914

1914

1914

1914

W. A. K. W. A. K. W. A. K.

W. A. K. W. A. K. W. A. K.

W. A. K. W. A. K. W. A. K.

W. A. K. W. A. K. W. A. K.

W. A. K. W. A. K. W. A. K.

W. A. K. W. A. K. W. A. K.

W. A. K. W. A. K. W. A. K.

W. A. K. W. A. K. W. A. K.

W. A. K. W. A. K. W. A. K.

W. A. K. W. A. K. W. A. K.

W. A. K. W. A. K. W. A. K.

W. A. K. W. A. K. W. A. K.

W. A. K. W. A. K. W. A. K.

W. A. K. W. A. K. W. A. K.

W. A. K. W. A. K. W. A. K.

W. A. K. W. A. K. W. A. K.

W. A. K. W. A. K. W. A. K.

W. A. K. W. A. K. W. A. K.

W. A. K. W. A. K. W. A. K.

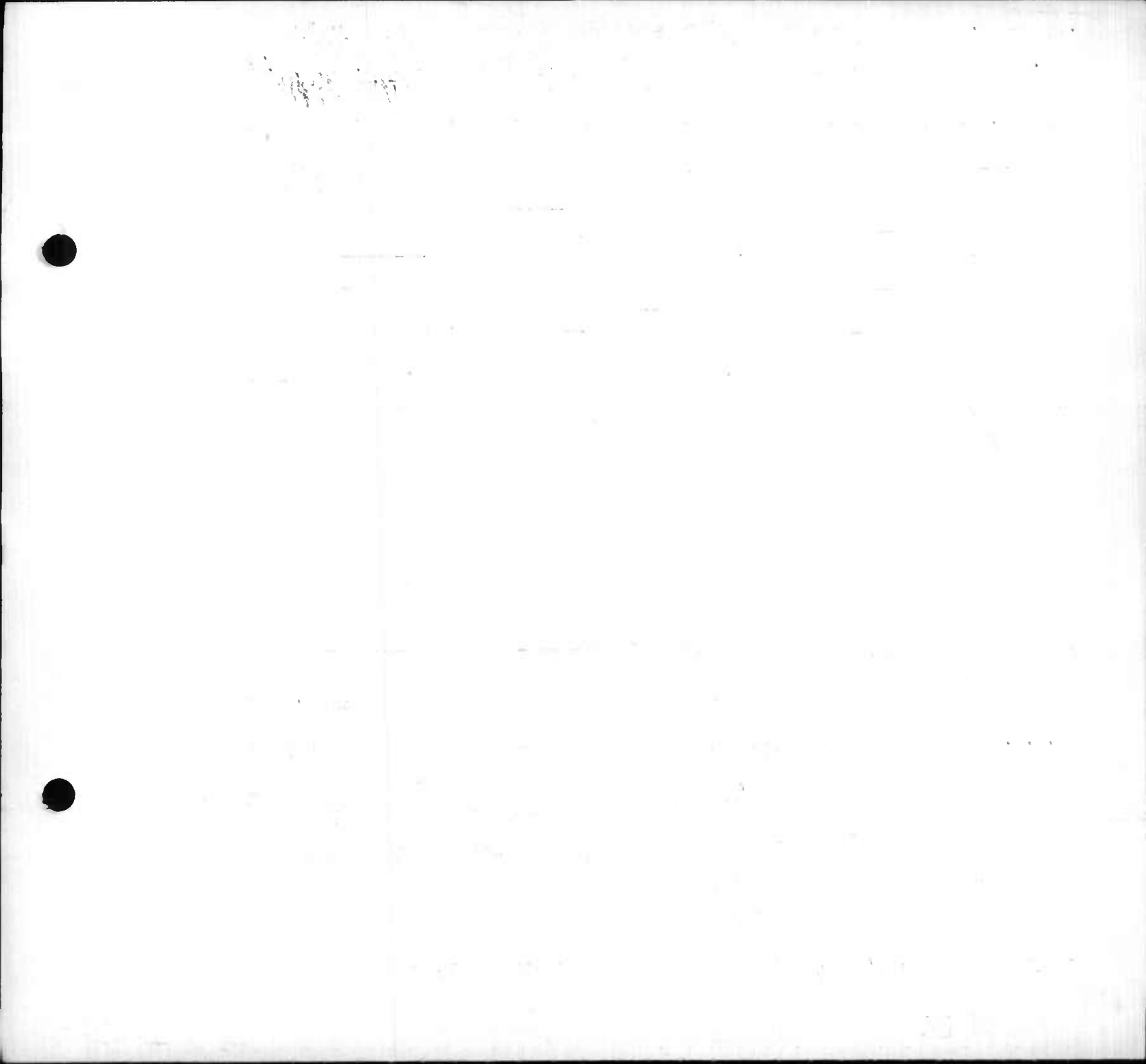
W. A. K. W. A. K. W. A. K.

W. A. K. W. A. K. W. A. K.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 11564		REG. NO. 72 11564	
72 11564				STATE OF MARYLAND-DHMH		M.	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				Grace Pauline Johnson		December 4, 1972 11:26A.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION				A. STATE		B. COUNTY	
43 South Baltimore General Hospital				Maryland		2302	
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				1627 Olive Street			
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
Female		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		June 13, 1918	
						9. AGE (In years last birthday) 54	
						10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife						West Virginia	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Samuel M. Know				Charlotte May Nester		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no				512-76-6689		Charles Walter Johnson 1627 Olive Street	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		1 year	
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II				Diabetes mellitus		2 years	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
11-12-71		Ca. of left breast		no.			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
no.							
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from January 11, 1957 to March 7, 1972 that (I) (we) last saw the deceased alive on March 7, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
C. C. Chiu, M.D.				12-5-72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
C. C. Chiu, M. D.				1 E. Randall Street, Baltimore, Md. 21203			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		12/7/72		Holy Cross Cemetery		Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
DEC 6 1972		Sidney J. Hester		McCurdy Funeral Homes		130 E. Font Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 11565	
72 11565 CERTIFICATE OF DEATH				STATE OF MARYLAND-DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>EVA T CICHORZ</b>		2. DATE AND HOUR OF DEATH <b>5 DEC 72 605 am</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>CHURCH HOME AND HOSPITAL</b> <b>35</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>201</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>105 S. WOLFEST.</b>		
5. SEX <b>F</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-24-05</b>	9. AGE (in years last birthday) <b>67</b>	10. UNDER 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MD</b>	
13. FATHER'S NAME <b>MICHEL KACZORSKI</b>			14. MOTHER'S MAIDEN NAME <b>C. WILYZWSKI</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>218-03-6186</b>		17. INFORMANT <b>CHART</b> ADDRESS <b>CHURCH HOME HOSP.</b>	
18. <b>410.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>MYOCARDIAL INFARCTION</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>MYOCARDIAL INFARCTION</b> (B) <b>HYPERTENSIVE VASCULAR DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>CONGESTIVE HEART FAILURE</b>		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>DEC 4</b> 19 <b>72</b> to <b>DEC 5</b> 19 <b>72</b> that (1) (we) last saw the deceased alive on <b>DEC 4</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Adolfo G. Torres</b> M.D. DEGREE			23B. DATE SIGNED <b>5 DEC '72</b>		23C. PHYSICIAN'S NAME (Type) <b>ADOLFO G. TORRES</b> M.D. DEGREE
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>			24B. DATE <b>DEC 8 1972</b>		24C. NAME OF CEMETERY or CREMATORY <b>ST. STANISLAUS CEMETERY</b>
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE MARYLAND</b>			25A. DATE REC'D BY HEALTH DEPT. <b>DEC 6 1972</b>		
25B. NAME OF REGISTRAR <b>Sidney W. Dipple</b>			25C. FUNERAL DIRECTOR <b>BROS 1800 E Lombard St.</b>		

DU 8415

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 11566		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 72 11566	
CERTIFICATE OF DEATH					
BIRTH NO.		STATE OF MARYLAND-DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Dr Robert M. Hening		12/3/72		5:25 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
90 Hood Nursing Home 5313 Edmonson Ave Balt. Md.		Md. Baltimore			
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Catonsville, Md.		YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		203 Ingleside Ave.			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE in years (last birthday)	10. Under 1 Yr. Months Days
Male	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Sept 30 1882	89	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Physician		Medical		Minn.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Unknown		Unknown		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
Yes WW I		220-46-4149		Otho E. Gilbert	
				ADDRESS 1014 Fidelity Bldg. Baltimore, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		PNEUMONIA - PULMONARY OEDEMA A.C.U.D.			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) GENERALIZED AORTIC SCLEROSIS			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 10/7/72 to 12/3/72 that (I) (we) last saw the deceased alive on 12/1/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
John H. Shaw M.D.		12/3/72			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
John H. Shaw M.D.		5313 Edmonson Ave. Balt. Md 21228			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Cremation		12/6/72		Security Process, Inc.	
				Catonsville, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR, ADDRESS	
DEC 6 1972		Sidney H. Heston		Edw. S. MacNabb Sons, Inc. 301 Frederick Rd. Catonsville, Md.	

7000 4 2400 410 2300 4000000 240 240 240 240  
10/2/10  
10/1/10 10/1/10 10/1/10 10/1/10

2000000 2000000 2000000  
2000000 2000000 2000000  
2000000 2000000 2000000

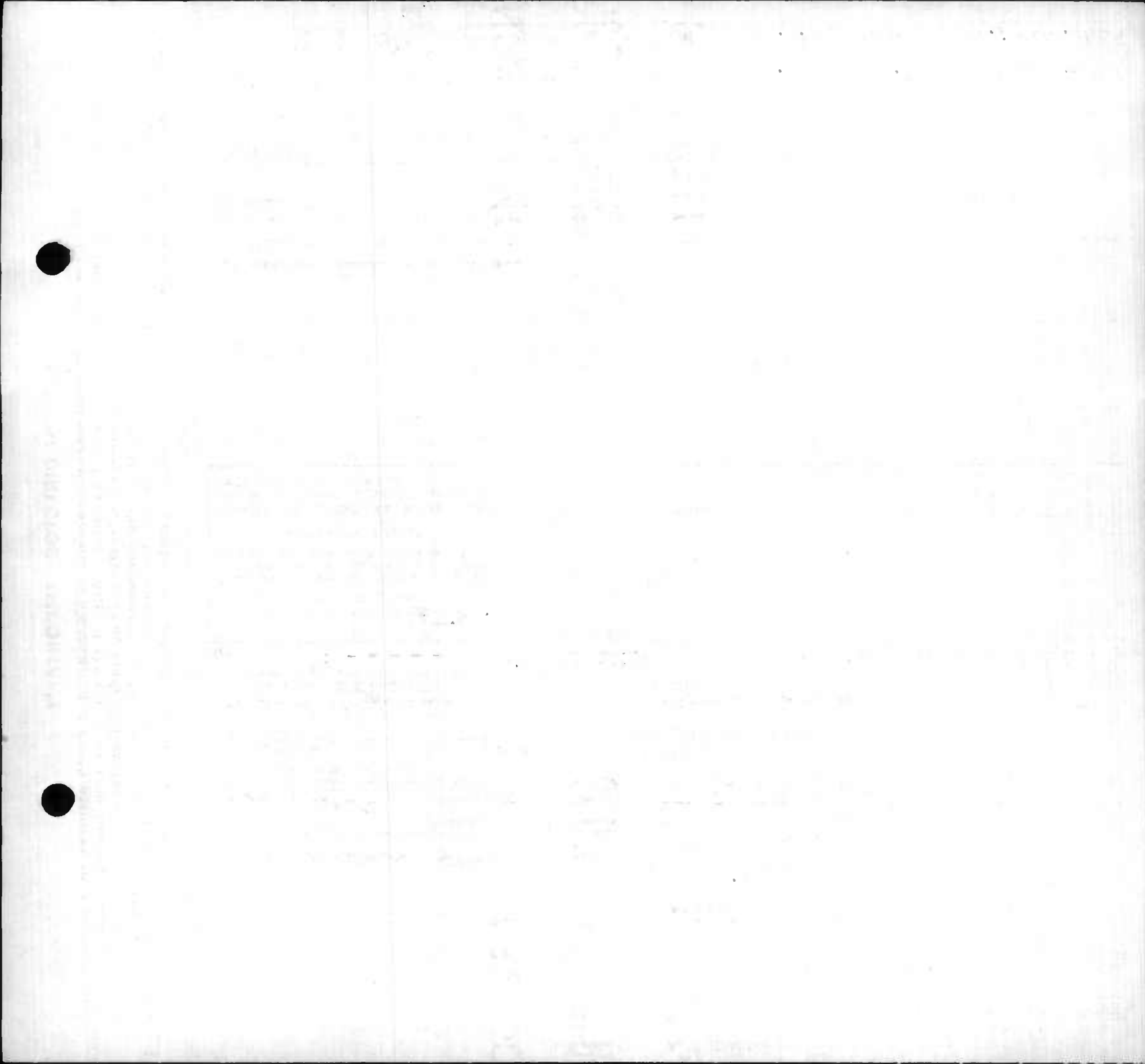
2000 2000 2000 2000 2000 2000 2000 2000  
2000 2000 2000 2000 2000 2000 2000 2000  
2000 2000 2000 2000 2000 2000 2000 2000



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

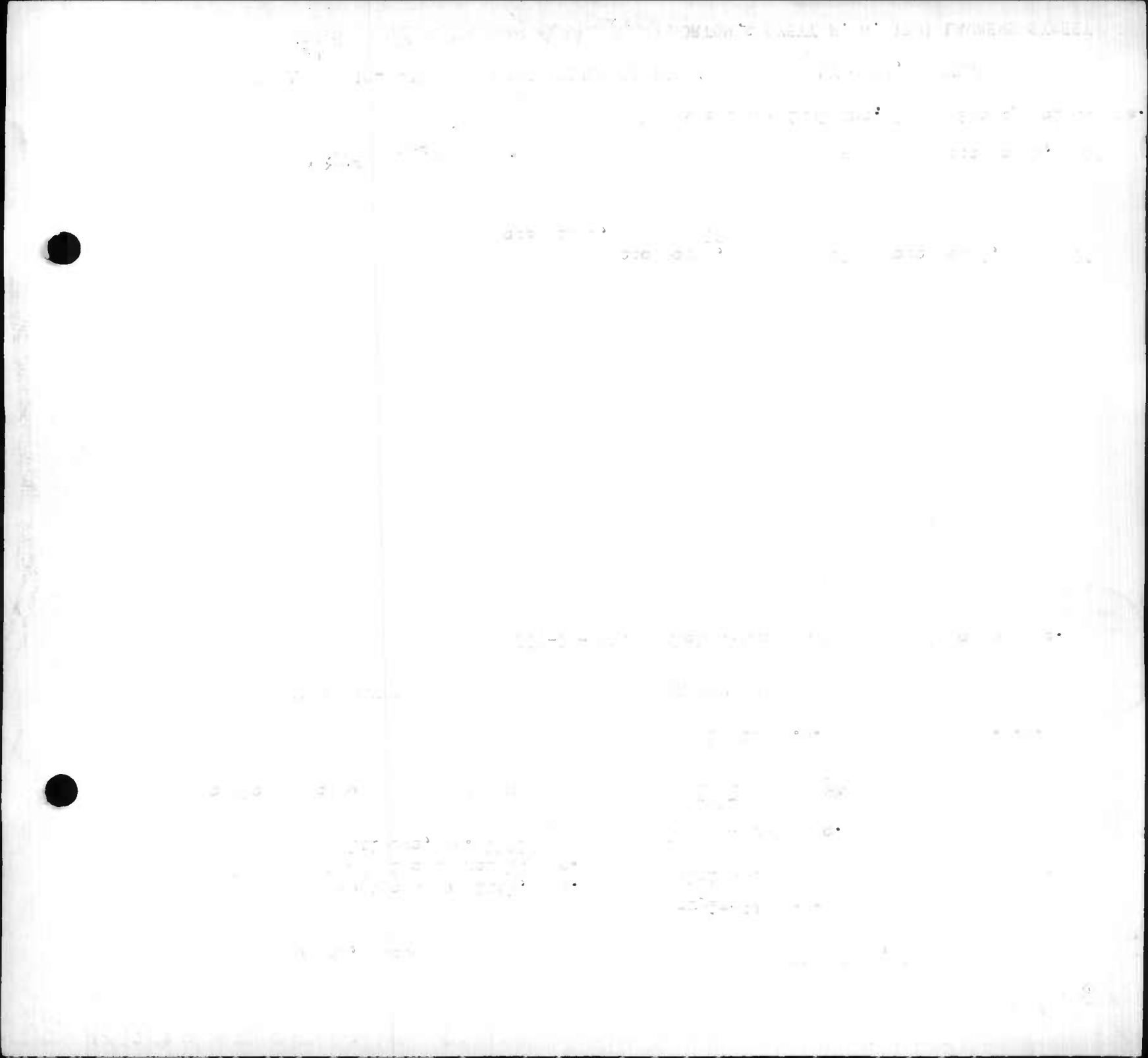
BIRTH NO. 72 11567				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 11567			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH				STATE OF MARYLAND-DEME			
MARCONI, LAURA G.				Dec. 5, 1972				3:00 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY							
43 South Baltimore General Hospital				Maryland Annie Arundel				5200			
				C. CITY OR TOWN				D. INSIDE CITY LIMITS?			
				Balto.				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
				E. STREET AND NUMBER							
				458 Gayle Dr.							
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. Under 1 Yr. Months Days	
Female		White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Feb 7, 1905		67			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)			
Housewife				Home				Maryland			
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
USA				Millard D. Leister				Mamie Upperman			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service				16. SOCIAL SECURITY NO.				17. INFORMANT			
No				230-2467				Louis Marconi (Son) 425 East Patapsco Ave. 21225			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE				Cerebral Vascular Accident			
ANTECEDENT CAUSES				DUE TO, OR AS A CONSEQUENCE OF:				Diabetes mellitus & Hypertension			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:							
(C) _____											
II											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)			
								20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?			
(APPROX.)				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from Nov. 22 1972 to Dec. 5, 1972 that (I) (we) last saw the deceased alive on Dec 5, 3:00 Am 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE								23B. DATE SIGNED			
Chang								Dec. 5 1972			
23C. PHYSICIAN'S NAME (Type)								23D. ADDRESS			
J.S. CHANG MD.								South Baltimore General Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE				24C. NAME OF CEMETERY OR CREMATORY			
Burial				12/8/1972				Glen Haven Cemetery			
24D. LOCATION (City, town, or county) (State)				25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR			
A. Arundel Co.; Glen Burnie, Md. 21061				DEC 6 1972				Audrey W. Houston			
25C. FUNERAL DIRECTOR				25D. ADDRESS							
No Call F.A.				237 Patapsco Ave.; Balto. 21225							



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 72 11568 CERTIFICATE OF DEATH				REG. NO. 72 11568 STATE OF MARYLAND-DEMD	
BIRTH NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>Hoover, Thelma</b>			DECEMBER 5, 1972		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>39</b> Provident Hospital, Inc. 2600 Liberty Height Ave. Baltimore, Md. 21215			A. STATE <b>Maryland</b>		B. COUNTY <b>1512</b>
5. SEX <b>Female</b>			6. RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			8. DATE OF BIRTH <b>10-31-18</b> <b>Washington</b>		9. AGE (In years last birthday) <b>54</b>
10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <b>Washington D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>HEZEKIAH COATES</b>			14. MOTHER'S MAIDEN NAME <b>DAISEY REDDER</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>577-34-8487</b>		17. INFORMANT <b>Ethel Lomax (DAUGHTER) 4907 Nelson Ave.</b>
18. <b>492X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>BRONCHOPNEUMONIA</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Chronic pulmonary emphysema and fibrosis</b>			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>BRONCHOPNEUMONIA</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Bleeding peptic ulcer of stomach</b>			(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Chronic pulmonary emphysema and fibrosis</b>		
19A. DATE OF OPERATION <b>2</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>December 1, 1972</b> to <b>December 5, 1972</b> that (I) (we) last saw the deceased alive on <b>December 5, 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>M. J. Shafel</b>			23B. DATE SIGNED <b>December 6, 1972</b>		
23C. PHYSICIAN'S NAME (Type) <b>M. JAVARD SHAFEL</b>			23D. ADDRESS <b>Provident Hospital Inc. 2600 Liberty Height Ave.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12-9-72</b>	24C. NAME OF CEMETERY or CREMATORY <b>MOUNT AUBURN CEMETERY</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 6 1972</b>		25B. NAME OF REGISTRAR <b>Adrian H. Hinton</b>		25C. FUNERAL DIRECTOR <b>MORTON &amp; DYETT F. H. 1701 LAURENS STREET</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 11569	
72 11569				STATE OF MARYLAND-DEM	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Williams, Shirley		December 4, 1972 10:30 a.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital, Inc. 2600 Liberty Height Ave. Baltimore, Md. 21215			A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1305 Homewood Ave.		
5. SEX Female	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-22-34	9. AGE (In years last birthday) 38	10. Under 1 Yr. Months: Ooys: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				Maryland, BALTIMORE	
13. FATHER'S NAME HERBERT CALDWELL			14. MOTHER'S MAIDEN NAME EDMONIA CARTER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-30-7587		17. INFORMANT Edmonia Caldwell (Mother) 815 Bethane Rd.	
		N/A		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE CIRCULATORY FAILURE DUE TO RESPIRATORY FAILURE DUE TO ACUTE INTESTINAL OBSTRUCTION FOLLOWING PERITONITIS DUE TO TUBERCULOSIS II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			CAUSE OF DEATH ACUTE CIRCULATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
					NO
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Not by medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from December 3, 1972 to December 4, 1972, that (I) (we) last saw the deceased alive on December 4, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE DILIP K. GUJA MD.				23B. DATE SIGNED 12/5/72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS Provident Hospital 2600 Liberty Height Ave.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		12-8-72		MOUNT AUBURN CEMETERY	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
DEC 6 1972		Sidney H. Heston		MORTON & DYETT F. H. 1701 LAURENS STREET	

SECRET  
U.S. DEPARTMENT OF THE ARMY  
OFFICE OF THE CHIEF OF STAFF  
WASHINGTON, D.C.

~~SECRET~~

000000

000000

000000

1. The purpose of this document is to provide information regarding the activities of the [redacted] in the [redacted] area. This information is being provided for your information and is not to be distributed outside your agency.

SECRET

SECRET

000000

000000

000000

000000

000000

000000

000000

000000

000000

000000

000000



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 72 11570		STATE OF MARYLAND		CERTIFICATE OF DEATH		REG. NO. 72 11570	
1. NAME OF DECEASED (Type or Print) <u>JORDAN, WILLIE MAE</u>				2. DATE AND HOUR OF DEATH <u>12/2/72</u> <u>4:20 P</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence, before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1601</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>JOHNS HOPKINS HOSPITAL</u>				C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER <u>908 HARLEM AVE</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>BLACK</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>08-16-09</u>	9. AGE (In years last birthday) <u>63</u>	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOE Thomas Jordan</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. Was Deceased Ever in U. S. Armed Forces (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>John Jordan</u>		ADDRESS <u>Same</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>174X I</u> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH <u>SEPTIC SHOCK, 5 ASTROINTESTINAL BLEEDING</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>METASTATIC BREAST CARCINOMA 4 yrs.</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
19. DATE OF OPERATION <u>0</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indefinitely medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) 1 Month 1 Day 1 Year 1 Hour		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (if hospital) attended the deceased from <u>NOV 8</u> 19 <u>72</u> to <u>DEC 2</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>DEC 2</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Ernest N. Arnett</u>				23B. DATE SIGNED <u>DEC 2, 1972</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) <u>ERNEST N. ARNETT</u>				23D. ADDRESS <u>THE JOHNS HOPKINS HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11-5-72</u>		24C. NAME of CEMETERY or CREMATORY <u>MT. Auburn Cem</u>		24D. LOCATION (City, town, or county) (State) <u>Ba Ho. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 6 1972</u>		25B. NAME OF REGISTRAR <u>Sidney Winston</u>		25C. FUNERAL DIRECTOR <u>CE [unclear] 8. Wilson 1000 Brimley</u>			

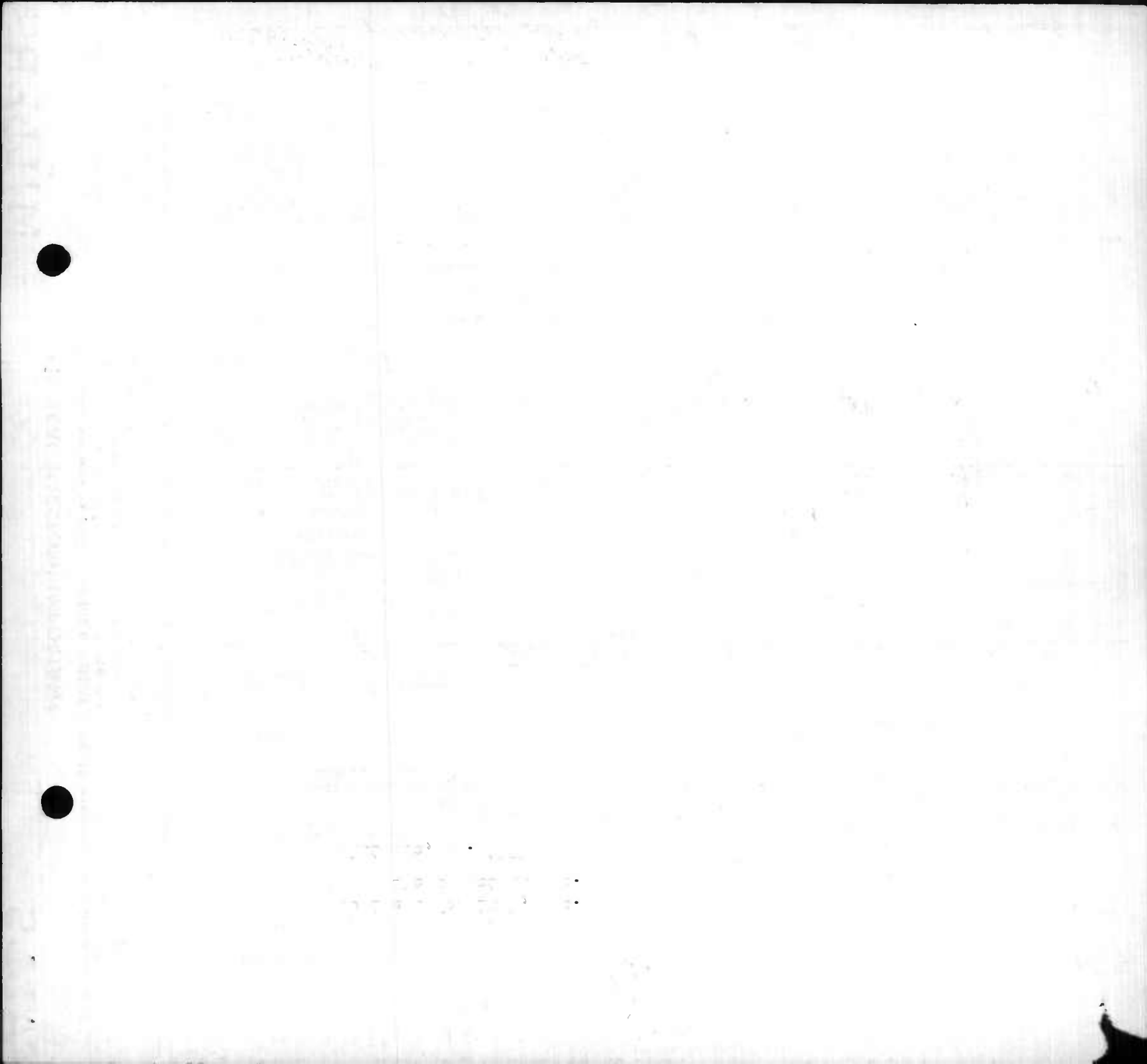




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 11571		REG. NO. 72 11571	
BIRTH NO. 72 11571				CERTIFICATE OF DEATH			
STATE OF MARYLAND				DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>OLIVIA THOMPSON</b>				2. DATE AND HOUR OF DEATH <b>12-4-72 8:10 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Provident Hospital, Inc. 2600 Liberty Height Ave. Baltimore, Md. 21215</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1606</b>			
5. SEX <b>F</b> 6. RACE <b>B</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
8. DATE OF BIRTH <b>2-10-20</b> 9. AGE (in years last birthday) <b>52 yrs.</b>				E. STREET AND NUMBER <b>2942 Edmonson Ave.</b>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME			
14. MOTHER'S MAIDEN NAME				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>03-193370</b>				17. INFORMANT <b>John L. Thompson - Husband</b> ADDRESS <b>SAME</b>			
18. <b>180X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of the Cervix</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>with widespread metastasis</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
19. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR?				22. I certify that (I) (this hospital) attended the deceased from <b>11-9</b> <b>1972</b> to <b>12-4</b> <b>1972</b> that (I) (we) last saw the deceased alive on <b>12-4</b> <b>1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Virginia F. Mercado, M.D.</b> DEGREE				23B. DATE SIGNED <b>12/4/72</b>		23C. PHYSICIAN'S NAME (Type) <b>VIRGINIA F. MERCADO, M.D.</b> DEGREE	
23D. ADDRESS <b>Provident Hospital Inc.</b>				24A. BURIAL, CREMATION, REMOVAL (Specify) <b>12-72</b>			
24B. DATE				24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State) <b>md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 6 1972</b>				25B. NAME OF REGISTRAR <b>Audrey Houston</b>		25C. FUNERAL DIRECTOR <b>Robertson 1000 Brawley</b> ADDRESS	



A-536

72 11572

BALTIMORE CITY HEALTH DEPARTMENT

72 11572

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

## STATE OF MARYLAND-DMH

REG. NO.

BIRTH NO.

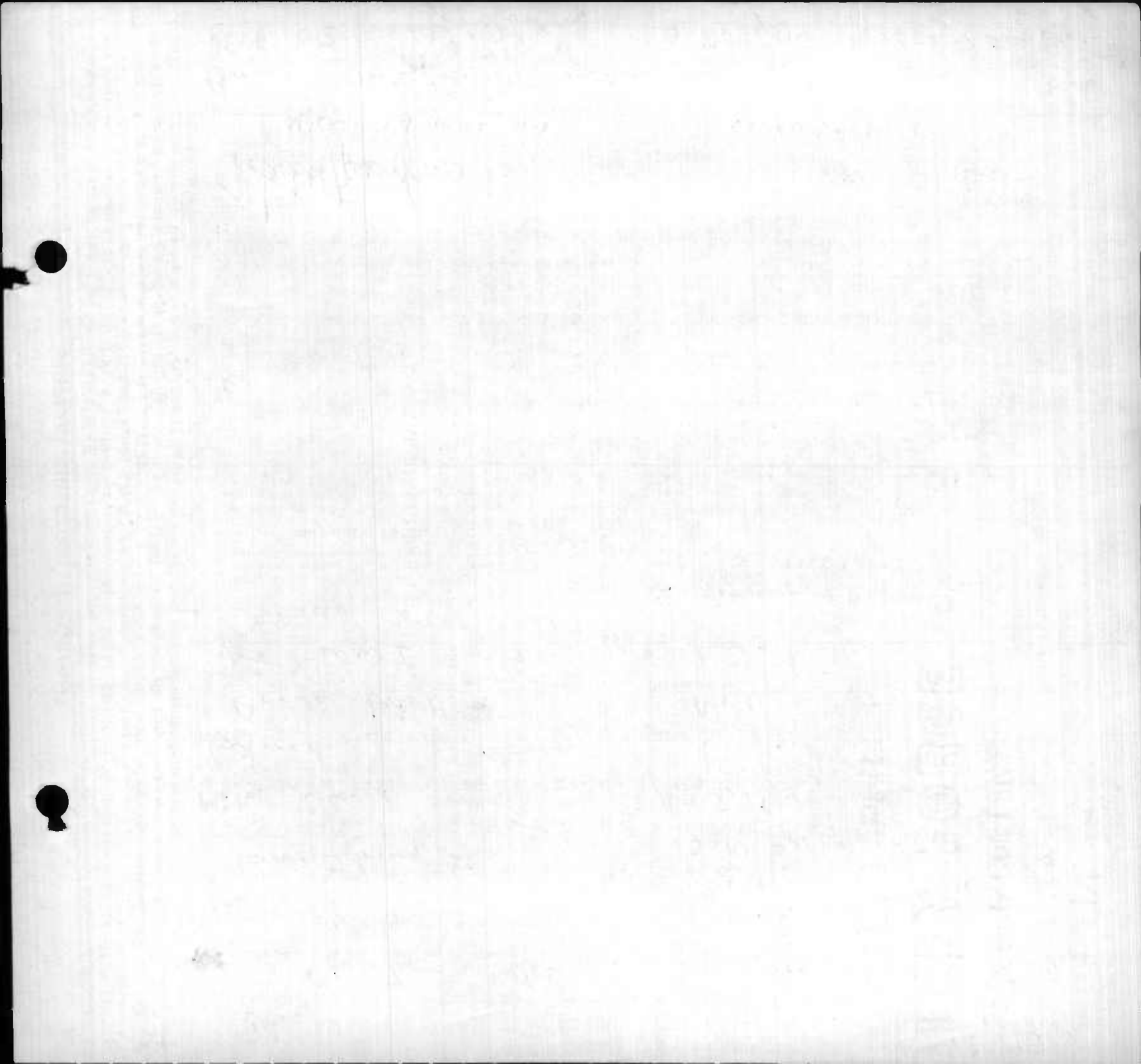
1. NAME OF DECEASED (Type or Print) <b>EASKERLEE . ANDERSON</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>2708 Talbot Road, Apt. T. 12-12-72</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>December 3, 1972 7:30 A.M.</b>	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>Dec. 25, 1928</b>		10. AGE (In years last birthday) <b>44</b>	
11. BIRTHPLACE (State or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Algeron Anderson</b>		14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2843</b>	
15. MOTHER'S MAIDEN NAME <b>Macy Boulevard</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b>	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS <b>Macy Ody 3406 Roslyn Rd.</b>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Fatty metamorphosis of liver</b> <b>Acute Ethylism</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Hydrocephalus</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>12/3/72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-7-72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>MT. Auburn Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 6 1972</b>		25B. NAME OF REGISTRAR <b>Sidney L. Heston</b>	
25C. FUNERAL DIRECTOR <b>Edmund O. Wilson</b>		25D. ADDRESS <b>1000 Brantley Ave. Baltimore Md.</b>	

12-12-1972 - Letter from the Office of the Chief Medical Examiner, Ronald N. Kornblum, M.D.  
Deputy Chief Medical Examiner. HS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 11573		72 11573	
BIRTH NO.		72 11573		REG. NO.	
1. NAME OF DECEASED (Type or Print)		STATE OF MARYLAND - DEATH		DATE AND HOUR OF DEATH	
Clinton Willis		Dec. 1 <sup>st</sup> 1972		2 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY		C. CITY OR TOWN	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		Maryland		301	
30 N. Spring St.		Baltimore		INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER		30 N. Spring St.			
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
Male		Colored		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH		9. AGE (in years lost birthday)		10. UNDER 1 Yr. Months: Days	
Dec. 5, 1894		78 77		11. UNDER 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired		None		Virginia	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Arnon Willis		Nellie		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
Yes WWI		218-01-2331A		Letha Willis -	
18. CAUSE OF DEATH		19. ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		Brochogenic Carcinoma			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		c metastases	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) lost saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Mark H. Kasowitz, MD				12-6-72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
MARK H. KASOWITZ, MD				LOCH RAVEN VA Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		12-6-72		Mt. Auburn Cem.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
DEC 6 1972		Sidney Johnston		G. E. Wilson	
25D. LOCATION (City, town, or county) (State)		25E. ADDRESS		25F. ADDRESS	
Baltimore Md.		1000 Barnhill Ave.			





1  
W-425

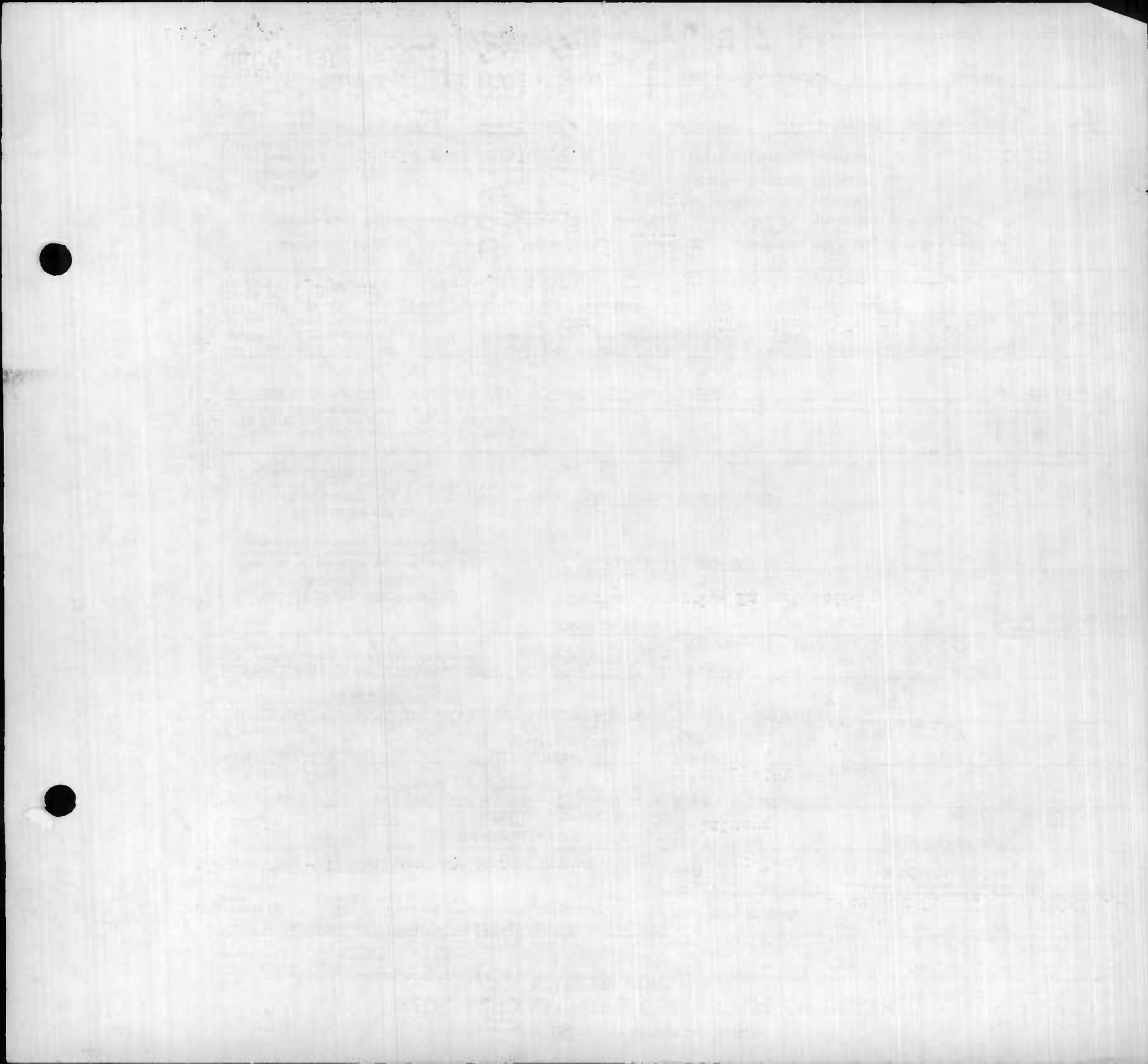
72 11574

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 11574

BIRTH NO.		STATE OF MARYLAND - DIME		REG. NO.	
1. NAME OF DECEASED (Type or Print) MABEL WILSON		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year Hour	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) IN AUTO - 2300 Block Cylburn Avenue		3. DATE PRONOUNCED DEAD December 2, 1972		7:30 P.M.	
6. SEX Female		7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH May 10 1941		10. AGE (in years lost birthday) 31 30		11. BIRTHPLACE (State or foreign country) Monroe, N. Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Thomas W. Johnson		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Odessa Blakely	
15. MOTHER'S MAIDEN NAME Odessa Blakely		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. [redacted]	
18. INFORMANT Laron Wilson		19. CAUSE OF DEATH Carbon monoxide Intoxication		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Car		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? 2300 Block Cylburn Avenue	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) December 1-2-1972 Unk.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Inhaled carbon monoxide	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12/3/72	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12- -72		24C. NAME of CEMETERY or CREMATORY	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. DEC 6 1972		25B. NAME OF REGISTRAR Sidney [redacted]	
25C. FUNERAL DIRECTOR		25D. ADDRESS		25E. ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

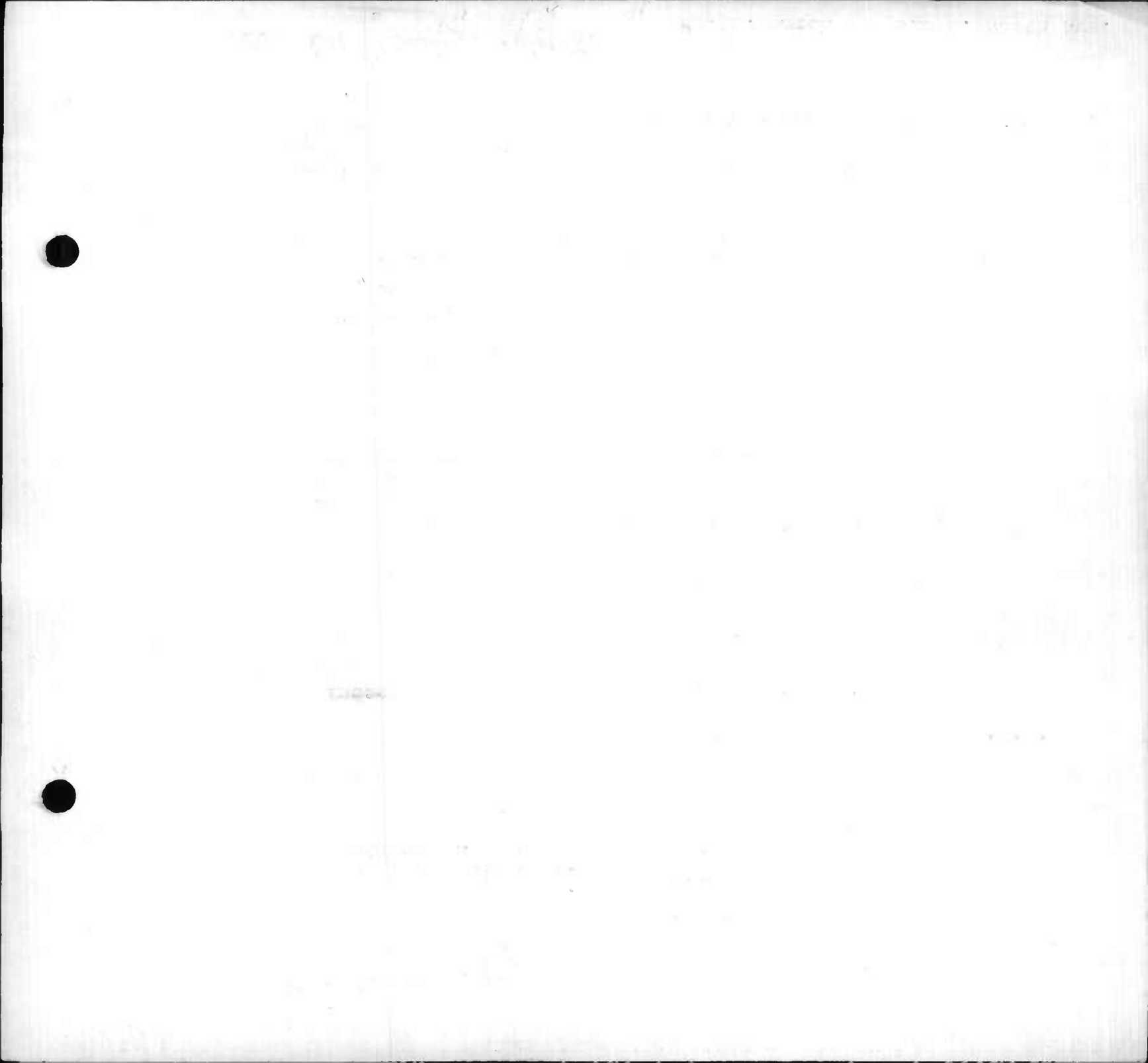
H-6101

72 11575

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 72 11575

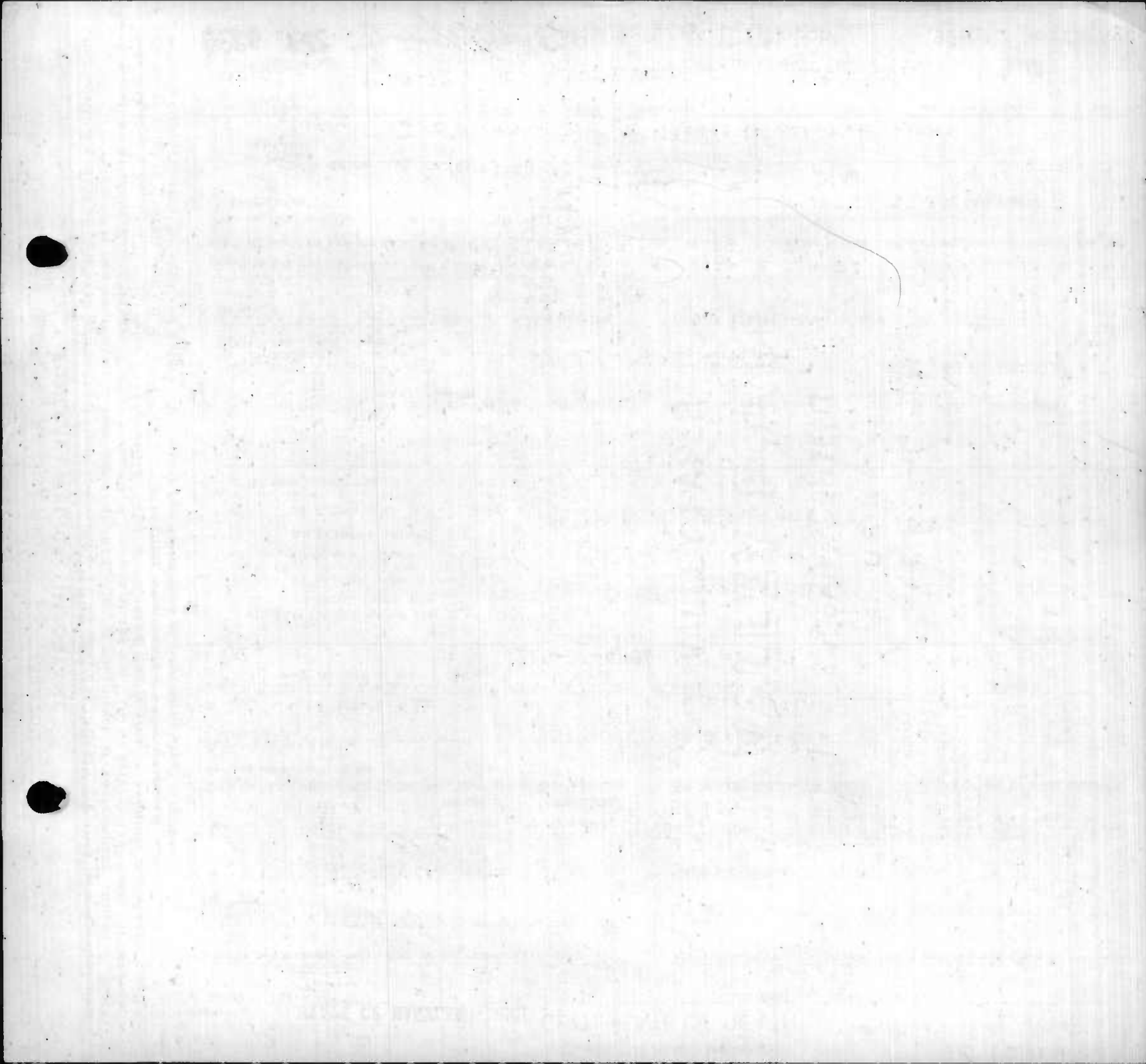
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>STATE OF MARYLAND - DEATH</b> <b>HELEN HARVEY</b>		2. DATE AND HOUR OF DEATH <b>Dec. 4, 1972</b> <b>2:35 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1761</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>39</b>			C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>2600 Liberty Height Ave. Baltimore, Md. 21215</b>			E. STREET AND NUMBER <b>1514 Apt. 501 Dolphin St.</b>		
5. SEX <b>F</b>	6. RACE <b>B</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-15-06</b>	9. AGE (In years last birthday) <b>66</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
13. FATHER'S NAME <b>Richard Lindsey</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Stanley Harvey</b>	
				ADDRESS <b>3817 Courtleigh Dr.</b>	
18. <b>73101</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>CEREBRAL HEMORRHAGE</b> DUE TO, OR AS A CONSEQUENCE OF: <b>HYPERTENSIVE ENCEPHALOPATHY</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>2-3 days</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Dec 2</b> 19 <b>72</b> to <b>Dec 4</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>Dec 4</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Janet V. Moghbeli, MD</b>				23B. DATE SIGNED <b>12-4-72</b>	
23C. PHYSICIAN'S NAME (Type) <b>JANET V. MOGHBELI, MD</b>				23D. ADDRESS <b>Provident Hospital 2600 Liberty Height Ave.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
				24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 6 1972</b>		25B. NAME OF REGISTRAR <b>Stanley Harvey</b>		25C. FUNERAL DIRECTOR <b>Wm. C. March</b>	
				ADDRESS <b>928 E. North Ave.</b>	



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the MEDICAL EXAMINER'S OFFICE OF THE Chief Medical Examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 11576		REG. NO.	
BIRTH NO.				STATE OF MARYLAND - DEMO			
1. NAME OF DECEASED (Type or Print) <u>Tommy Lee Foster</u>				2. DATE AND HOUR OF DEATH <u>12/4/72 1130 a.m.</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>JOHNS HOPKINS HOSPITAL</u>				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER <u>2231 E. BIDDLE</u>			
5. SEX <u>m</u>	6. RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/1/39</u>	9. AGE (In years last birthday) <u>33</u>	If Under 1 Yr. Months: Days	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>construction</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>So. Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Willie Foster</u>			
14. MOTHER'S MAIDEN NAME <u>LILLIE MAE FOSTER</u>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>216-36-4984</u>				17. INFORMANT <u>WIFE</u> ADDRESS <u>Same</u>			
18. <u>291.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Germ Negative Septis</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Deer gun Trauma</u> (B) <u>Acute &amp; Chronic Asphyxia</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>10/26</u> 19 <u>72</u> to <u>12/4</u> 19 <u>72</u> , that (I) (we) last saw the deceased alive on <u>12/4/72</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Corwin Q. Edwards M.D.</u>				23B. DATE SIGNED <u>12/4/72</u>			
23C. PHYSICIAN'S NAME (Type) <u>CORWIN Q. EDWARDS</u>				23D. ADDRESS <u>JOHNS HOPKINS HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>12-9-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Auburn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 10 1972</u>		25B. NAME OF REGISTRAR <u>Anthony...</u>		25C. FUNERAL DIRECTOR <u>Wm. C. March</u>		ADDRESS <u>928 E. North Ave.</u>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH									
BIRTH NO. <u>BC 72-178601</u>					REG. NO. <u>72 11577</u>				
1. NAME OF DECEASED (Type or Print) <u>Henry (Baby Boy McNAIR) Terrell</u>					2. DATE AND HOUR OF DEATH <u>12/2/72 1:10 40 P M.</u>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <u>BAL T</u> B. COUNTY <u>MD</u>				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>UNION MEMORIAL HOSP.</u>					C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER									
5. SEX <u>M</u>	6. RACE <u>B</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/2/72</u>	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <u>BAL T, MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>									
13. FATHER'S NAME <u>TERRELL, Henry M.</u>					14. MOTHER'S MAIDEN NAME <u>CHARLENE McNaair</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Henry M. Terrell 333 Whitebridge Ave</u>		
18. <u>727X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>PREMATURITY</u> DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR		
22. I certify that (I) (this hospital) attended the deceased from <u>12/2</u> 19 <u>72</u> to <u>12/2</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>12/2</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Wm Waldman M.D.</u>					23B. DATE SIGNED <u>12/2/72</u>			23C. PHYSICIAN'S NAME (Type) <u>WALDMAN</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>					24B. DATE <u>12-6-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Ann Arundel Cty., MD</u>
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 6 1972</u>					25B. NAME OF REGISTRAR <u>Sidney Winston</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Wm Waldman 928 E North Ave</u>		



272 1002-1

W. W. W.

W. W.

323 WHITRIDGE AVE

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 11578	
72 11578 STATE OF MARYLAND - DECEASED CERTIFICATE OF DEATH					
BIRTH NO. 72 11578			1. NAME OF DECEASED (Type or Print) WASHINGTON, MRS. HATTIE		
2. DATE AND HOUR OF DEATH 12/2/72 12-25 A.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) CHURCH HOME & HOSPITAL 100 N. BROADWAY. BALTIMORE, MD.			A. STATE MD. B. COUNTY BALTIMORE 301		
5. SEX F			6. RACE N		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 6-18-88		
9. AGE (In years last birthday) 84 yrs			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ← HOME MAKER →		
11. BIRTHPLACE (State or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? AMER. USA		
13. FATHER'S NAME JOSEPH. SMITH			14. MOTHER'S MAIDEN NAME EMILIA CHASE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 220-344581		
17. INFORMANT MRS. FOOTE			ADDRESS TOWSON, M.D. 1-22769		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH CARDIO RESPIRATORY FAILURE		
ANTECEDENT CAUSES			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 mts.		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE 2 INTRACTABLE DUE TO, OR AS A CONSEQUENCE OF:		
			(B) GASTROINTESTINAL FAILURE ASHD ASTHMA DUE TO, OR AS A CONSEQUENCE OF: 20 days		
			(C) MANY YEARS? 15 yrs		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 22		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/24/1972 to 12/2/1972 that (I) (we) last saw the deceased alive on 12/2/1972 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE L. Padmaraju M.D. DEGREE			23B. DATE SIGNED 12/2/72		
23C. PHYSICIAN'S NAME (Type) L. PADMARAJU. M.D. DEGREE			23D. ADDRESS CHURCH HOME & HOSPITAL. BALTIMORE		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-9-72		24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery	
24D. LOCATION Annarundel Ct Md.		25A. DATE REC'D BY HEALTH DEPT. DEC 6 1972			
25B. NAME OF REGISTRAR Sidney Houston		25C. FUNERAL DIRECTOR ADDRESS 6575			

7 DUDWYR 17 10 0

X 10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

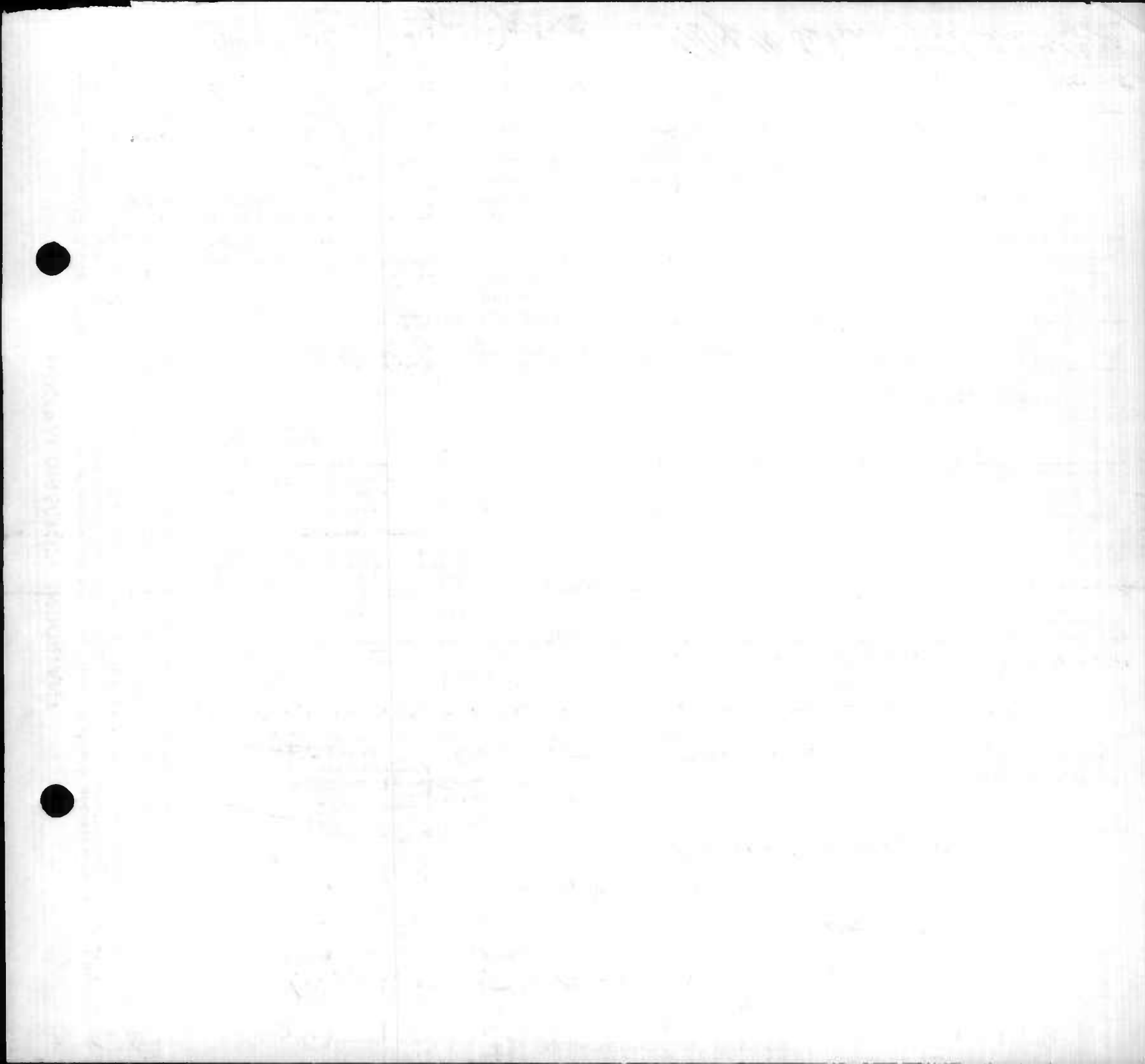
10/10/10

10/10/10

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

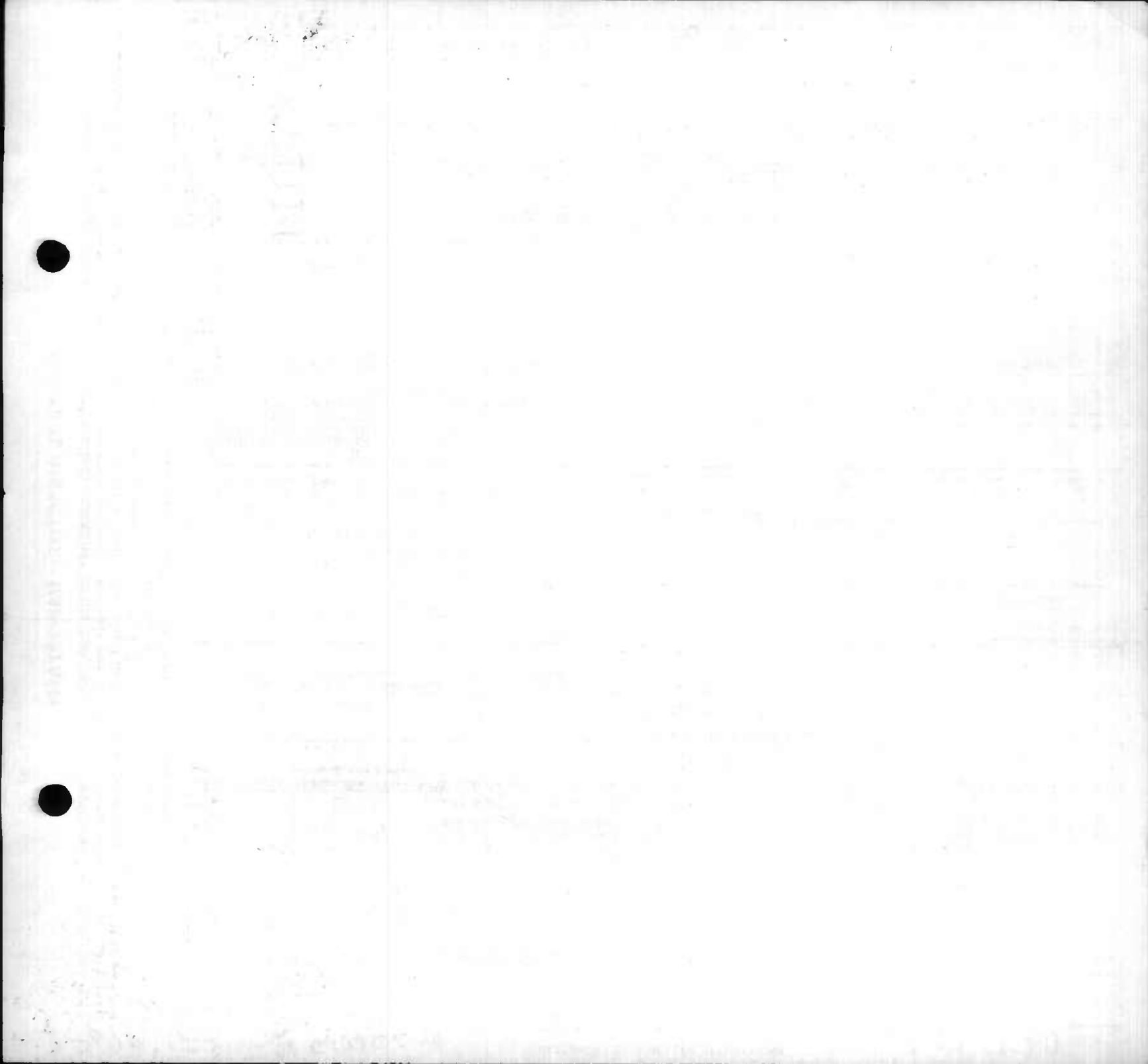
BIRTH NO. 72 11579		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 11579	
1. NAME OF DECEASED (Type or Print) <b>ADELBERT WILBUR ANDERSON</b>				2. DATE AND HOUR OF DEATH <b>11-30-72 1/15 P.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>WASHINGTON</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>MARYLAND General Hospital</b>				C. CITY OR TOWN <b>Linkstown</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>34 W. Cemetery St.</b>			
5. SEX <b>MALE</b>	6. RACE <b>CAUCASIAN</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>03-27-22</b>	9. AGE (In years last birthday) <b>50</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Cement</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
13. FATHER'S NAME <b>MILFORD GEORGE ANDERSON, SR.</b>				14. MOTHER'S MAIDEN NAME <b>EDITH MAY ZIMMERMAN</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes WWII</b>		16. SOCIAL SECURITY NO. <b>219-121431</b>		17. INFORMANT <b>MRS. ADELBERT W. ANDERSON</b>		ADDRESS <b>ITEM 4 ABOVE</b>	
18. <b>209X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>myelofibrosis</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3yr</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>11/20/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>myeloid meta plasia</b>		20A. AUTOPSY? (Yes or No) <b>no</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) Month Day Year Hour		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>11/6</b> 19 <b>72</b> to <b>4/30</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>1/30</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Robert W. Wensky M.D.</b>				23B. DATE SIGNED <b>11/30/72</b>		23C. PHYSICIAN'S NAME (Type) <b>Robert Wensky M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12/4/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>HAGERSTOWN, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 6 1972</b>		25B. NAME OF REGISTRAR <b>Adrian J. ...</b>		25C. FUNERAL DIRECTOR <b>W. M. ...</b>		ADDRESS <b>2244 FUNERAL HOME WILLIAMSPORT, MD</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND - DEMO		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>72 11580</u>	
BIRTH NO. <u>72 11580</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>MARY SHARP</u>			2. DATE AND HOUR OF DEATH <u>Dec. 1, 1972</u>   <u>6:50 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>909</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Provident Hospital</u> <u>Baltimore, Maryland</u>			C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>F</u> 6. RACE <u>B</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>05-03-17</u>		9. AGE (in years last birthday) <u>53</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed</u>			11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Walter Woolford</u>			14. MOTHER'S MAIDEN NAME <u>Birdie Parr</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service			16. SOCIAL SECURITY NO. <u>214 12 9198</u>		17. INFORMANT <u>Mr. Joseph Sharp</u>
18. <u>230.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH <u>Acute</u> (A) IMMEDIATE CAUSE <u>Possible Pulmonary Embolism</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Cellulitis of Right Leg</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Diabetes mellitus</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>28 days</u> <u>10 years</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>11-06-72</u> 19 to <u>12/1/72</u> 19 that (I) (we) last saw the deceased alive on <u>12/1</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Rodolfo Quion M.D.</u>				23B. DATE SIGNED <u>12/1/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Rodolfo Quion M.D.</u>				23D. ADDRESS <u>Provident Hospital, Balto, Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>		24B. DATE <u>12/6/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Calvary</u>	
24D. LOCATION <u>Baltimore, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 6 1972</u>			
25B. NAME OF REGISTRAR <u>Indy In...</u>		25C. FUNERAL DIRECTOR <u>Mary E. Law</u>		ADDRESS <u>102 Madison</u>	

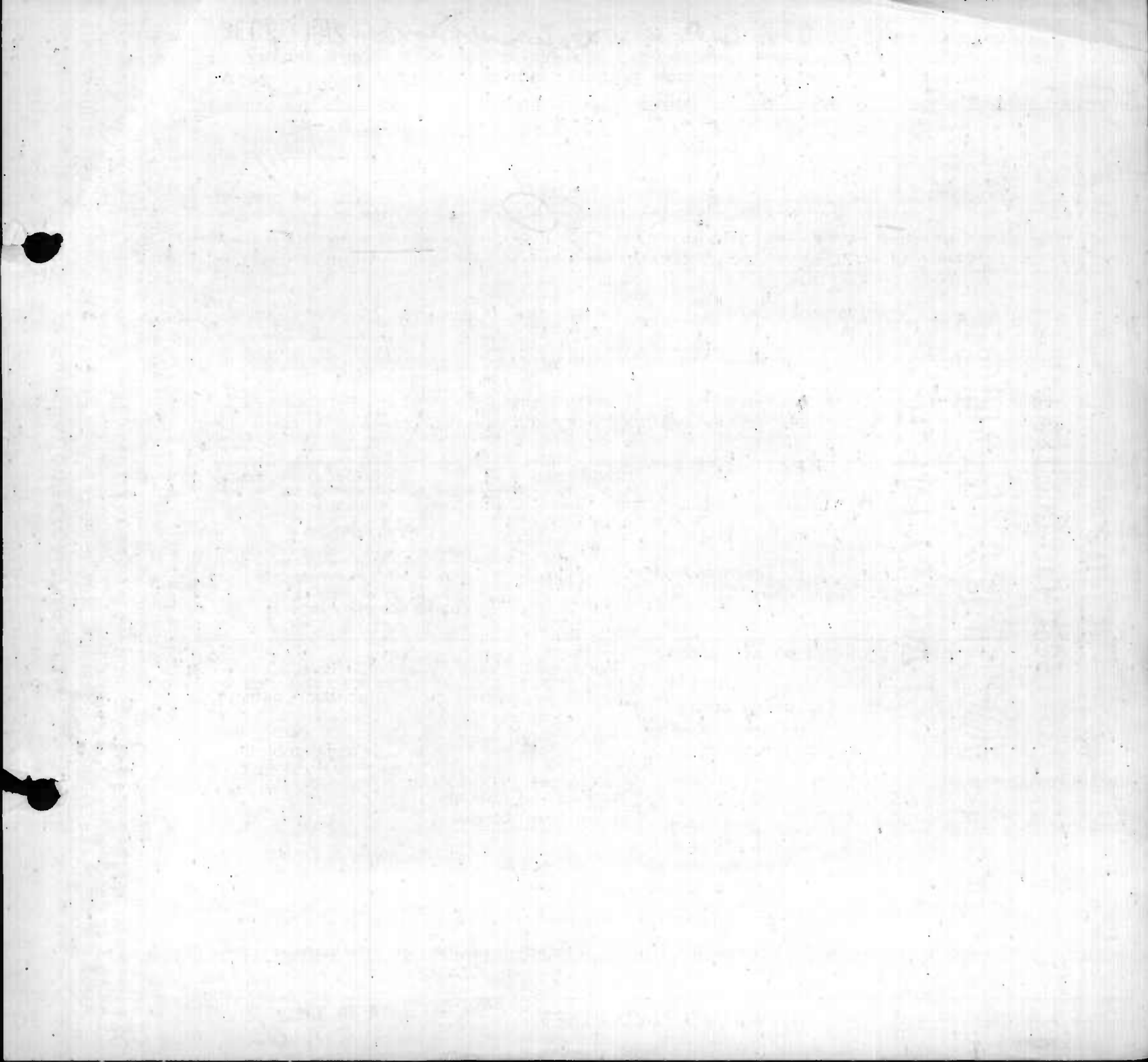




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

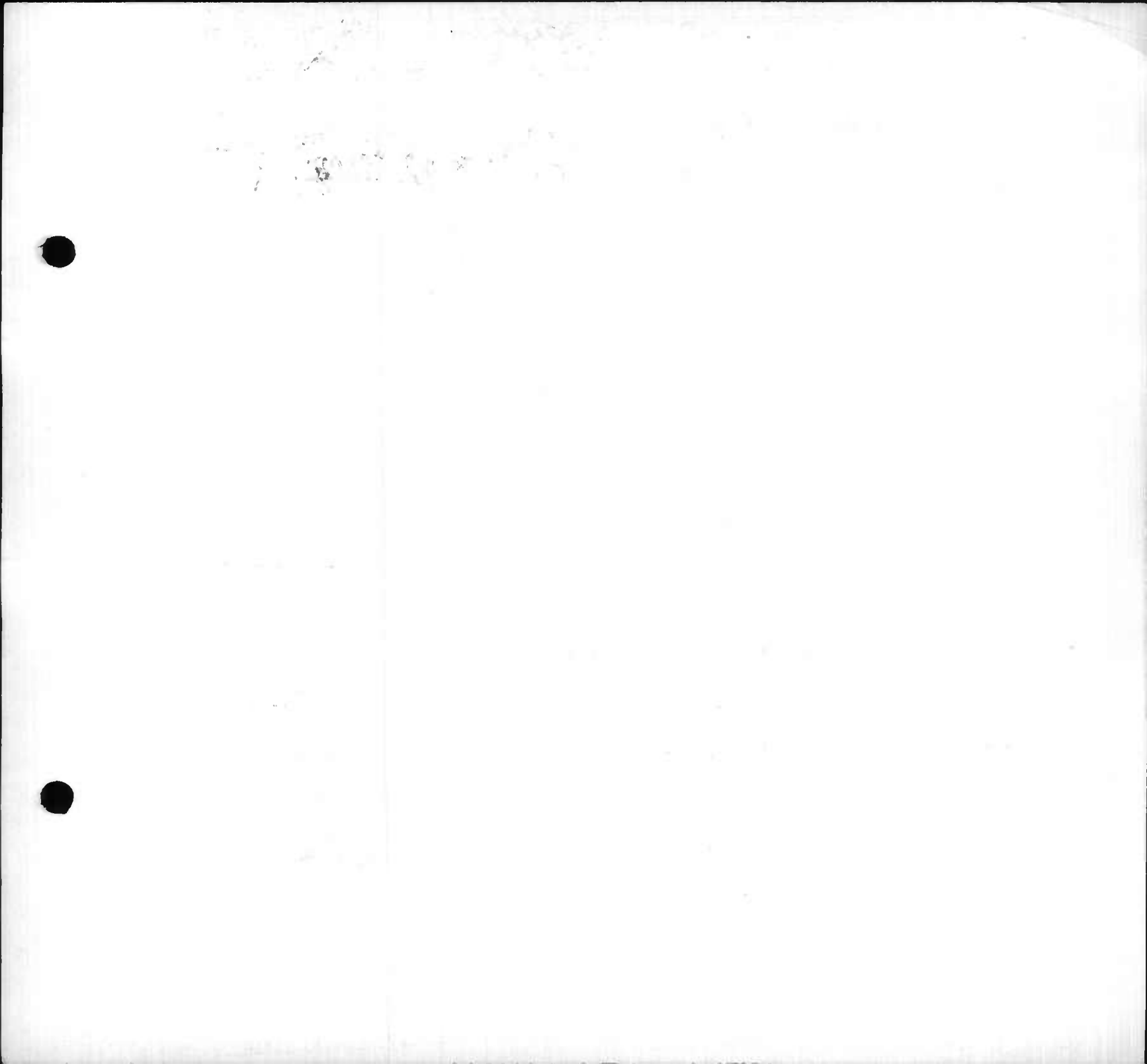
72 11581 STATE OF MARYLAND - DHMH CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 72 11581	
BIRTH NO. 72 11581		1. NAME OF DECEASED (Type or Print) <b>SAVAGE, LOTTENA</b>			
2. DATE AND HOUR OF DEATH <b>December 1st 1972 8:06 AM</b>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>The Johns Hopkins Hospital</b>			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2843</b>		5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>The Johns Hopkins Hospital</b>			
6. CITY OR TOWN <b>Baltimore</b>		7. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
8. STREET AND NUMBER <b>4315 Fairfax Road</b>		9. SEX <b>Female</b> 10. RACE <b>Negro</b> 11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 12. DATE OF BIRTH <b>4/06/13</b> 13. AGE (In years last birthday) <b>59</b> 14. If Under 1 Yr. Months: Days: 15. If Under 24 Hrs. Hours: Min.			
16. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		17. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		18. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
19. FATHER'S NAME <b>Luther Johnson</b>		20. MOTHER'S MAIDEN NAME <b>Irene Ryan</b>			
21. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		22. SOCIAL SECURITY NO.		23. INFORMANT ADDRESS <b>Jerome Savage 4315 Fairfax Rd.</b>	
24. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <b>Acute Myocardial Infarction</b>		25. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF <b>HASeVD</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>D. M.</b> (C) <b>Acute pul. edema, renal shut down sepsis</b>		26. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Days</b> <b>years</b> <b>years</b>	
27. MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Acute pul. edema, renal shut down sepsis</b>		28. MEDICAL CERTIFICATION 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) <b>NO</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
29. 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>November 27 1972</b> to <b>December 1 1972</b> , that (I) (we) last saw the deceased alive on <b>December 1 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Min-Fu Tsan</b>		23B. DATE SIGNED <b>December 1, 1972</b>		23C. PHYSICIAN'S NAME (Type) <b>Min-Fu Tsan, M.D.</b>	
23D. ADDRESS <b>514 A. N Bond St. Baltimore</b>		24. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
25A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		25B. DATE <b>12/5/72</b>		25C. NAME OF CEMETERY or CREMATORY <b>Arbutus Memorial Park</b>	
25D. LOCATION <b>Baltimore, Maryland</b>		25E. DATE REC'D BY HEALTH DEPT. <b>DEC 6 1972</b>			
25F. NAME OF REGISTRAR <b>Judith H. H. H.</b>		25G. FUNERAL DIRECTOR <b>Mary E. Law</b>		25H. ADDRESS <b>802 Madison Ave.</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND-DEMH 72 11582		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 11582	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Agnes J. Rico</i>		2. DATE AND HOUR OF DEATH <i>12/4/72</i> <i>5:25 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD</i> B. COUNTY <i>BALTIMORE</i>		1304	
FULL NAME OF HOSPITAL OR INSTITUTION <i>42 Sinai Hospital</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>3403 Woodbrook Ave #17</i>		5. SEX <i>Female</i> 6. RACE <i>BLACK</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>8/16/10</i>		9. AGE (in years last birthday) <i>62</i>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Edward Gray</i>		14. MOTHER'S MAIDEN NAME <i>Irene Johnson</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-26-2127</i>		17. INFORMANT <i>Percalli C. Rico</i> ADDRESS <i>3403 Woodbrook Ave.</i>	
18. <i>200.01</i> CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <i>Shock</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Retenium cell carcinoma</i> DUE TO, OR AS A CONSEQUENCE OF: (C)	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>Thrombocytopenia</i>		19A. DATE OF OPERATION <i>21</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <i>Yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH Initially medical examined		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>11/4/72</i> 19 <i>72</i> to <i>12/4</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>12/4</i> 19 <i>72</i> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <i>Kentley Miller, M.D.</i>		23B. DATE SIGNED <i>12/4/72</i>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <i>914 N. Charles St. 21201</i>		23E. DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12/9/72</i>		24C. NAME of CEMETERY or CREMATORY <i>Carver Memorial Pk</i>	
24D. LOCATION <i>Laurel, Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>DEC 6 1972</i>		25B. NAME OF REGISTRAR <i>Andrew H. Weston</i>	
25C. FUNERAL DIRECTOR <i>Mary E. Law</i>		25D. ADDRESS <i>802 Madison Ave.</i>		25E. DEGREE	



1  
J-525

72 11583

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 11583

BIRTH NO.		STATE OF MARYLAND-DEME		REG. NO.	
1. NAME OF DECEASED (Type or Print) GERALDINE JOHNSON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour M.		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 4 1972 9:05a M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 48 Maryland General Hospital		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 1701		6. SEX female 7. RACE negro 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 11/5/30		10. AGE (in years last birthday) 42		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles Bryson		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian	
15. MOTHER'S MAIDEN NAME Rosa Johnson		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 213-30-1446	
18. INFORMANT Mrs. Rosa Ferguson		19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Massive subarachnoid hemorrhage (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) congenital aneurysm of anterior communicating artery (C) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		20. DATE OF OPERATION 21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell S. Fisher, M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12-4-72					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/6/72		24C. NAME of CEMETERY or CREMATORY Western Star	
24D. LOCATION (City, town, or county) (State) Catonsville, Maryland		25A. DATE REC'D BY HEALTH DEPT. DEC 6 1972		25B. NAME OF REGISTRAR L. J. H. H. H.	
25C. FUNERAL DIRECTOR Mary E. Law		25D. ADDRESS 802 Madison Ave.			

1204 MAY



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 72 11584				BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH				REG. NO. 72 11584			
1. NAME OF DECEASED (Type or Print) Riggs, Minnie								2. DATE AND HOUR OF DEATH December 3, 1972 6:20 a.m.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD								4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION 39				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Provident Hospital, Inc. 2600 Liberty Height Ave. Baltimore, Md. 21215				A. STATE Georgia				B. COUNTY V09			
C. CITY OR TOWN SAVANNAH				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				E. STREET AND NUMBER 707 W. 60th St.							
5. SEX Female		6. RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-22-06		9. AGE (In years last birthday) 66		10. Under 1 Yr. Months: Days: Hours: Min.		11. Under 24 Hrs. Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Georgia				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Blitch Holloway								14. MOTHER'S MAIDEN NAME							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) No				16. SOCIAL SECURITY NO. 258-74-6355				17. INFORMANT ADDRESS Doris Scott (DAUGHTER) 5039 Green Mountain Cir							
18. CAUSE OF DEATH								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH								(A) IMMEDIATE CAUSE							
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)								DUE TO, OR AS A CONSEQUENCE OF: Autopsy is not done Possible cerebral thrombosis. (C.V.A.)							
ANTECEDENT CAUSES								(B) DUE TO, OR AS A CONSEQUENCE OF:							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.								(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).								Diabetic mellitus.							
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) NO				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (if in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from 11-7-1972 to 12-4-1972 that (I) (we) last saw the deceased alive on 12-4-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.															
23A. SIGNATURE R. m. Shak								23B. DATE SIGNED 12-4-1972							
23C. PHYSICIAN'S NAME (Type) R. m. Shak M.D.								23D. ADDRESS Provident Hospital							
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE 12-5-72				24C. NAME OF CEMETERY OR CREMATORY				24D. LOCATION (City, town, or county) (State) Savannah Georgia			
25A. DATE REC'D BY HEALTH DEPT. DEC 7 1972				25B. NAME OF REGISTRAR Sidney H. Hinton				25C. FUNERAL DIRECTOR H. S. Washington & Sons 4925 Deane Ave.							





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 72 11585	
72 11585				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND TIME OF DEATH	
		Julietta Roman		December 4, 1972 8:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE Md. City		
91 Jenkins Memorial hospital 1000 Caton Avenue Baltimore, Maryland 21229			C. CITY OR TOWN Baltimore		
			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER 4215 Parkton Street					
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
Female	Spanish		Jan. 27, 1884	88	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		None		Bogota, Colombia, S.A.	
13. FATHER'S NAME Miguel Sierra			14. MOTHER'S MAIDEN NAME Mariana Toscano		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		216-62-1228JI		Jenkins Memorial 1000 Caton Ave. 21229	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Congestive Heart Failure			7 DAYS		
(B) DUE TO, OR AS A CONSEQUENCE OF: H A S C V D			10 YRS.		
(C) CVA - Chronic Brain Syndrome					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			Generalized Dermatitis		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				NO	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from MAR. 20 1970 to DEC 4 1972, that (I) (we) last saw the deceased alive on DEC. 4 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John F. Hartman, M.D.				23B. DATE SIGNED 12-5-72	
23C. PHYSICIAN'S NAME (Type) John Hartman, M.D.				23D. ADDRESS 422 Med. Arts Bldg. Balto, Md. 21201	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		12-7-72		Glen Haven Cemetery	
24D. LOCATION (City, town, or county) (State)		Anne Arundel County Maryland			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
DEC 7 1972		Dorothy W. Hartman		Hubbard Funeral Home - Wilkens Ave.	

1-1-1

1-1-1

1-1-1

1-1-1

1-1-1

1-1-1

1-1-1

1-1-1

1-1-1

1-1-1

1-1-1

1-1-1

1-1-1

1-1-1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death was: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">72 11586</span>	
72 11586				STATE OF MARYLAND - DEPT. OF HEALTH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Bakunas, Peter		12/3/72 9:20 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>40 St. Agnes Hospital Baltimore, Md.</b>			A. STATE <b>Md.</b> B. COUNTY <b>2864</b>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <b>Balto., Md. 21229</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <b>4417 Manorview Rd.</b>					
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/2/10</b>	9. AGE (In years last birthday) <b>62</b>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance Man</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Comfort Springs Corp.</b>		11. BIRTHPLACE (State or foreign country) <b>Lithuania</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>Laurynas Bakunas</b>			14. MOTHER'S MAIDEN NAME <b>Gaudenciya Rakauskas</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>065-26-2857</b>		17. INFORMANT <b>Mrs. Ema Bakunas</b>
			ADDRESS <b>4417 Manor View Rd. 21229</b>		
18. CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
I <b>410.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Heart arrest - massive M.I.</b>			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Acute myocardial infarction on July 1972</b>			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) <b>Coronary disease</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1974 to Dec. 3, 1972</b> , that (I) (we) last saw the deceased alive on <b>Dec 3, 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Stanley Ankudas</i>				23B. DATE SIGNED <b>12.4.72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Stanley Ankudas</b>				23D. ADDRESS <b>1101 Maiden Choice Lane 21229</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12-7-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 7 1972</b>		25B. NAME OF REGISTRAR <i>Stanley Ankudas</i>		25C. FUNERAL DIRECTOR <b>Hubbard Funeral Home</b>	
				ADDRESS <b>4107 Wilkens Ave. 21229</b>	

1871-72 ANNUAL REPORT OF THE COMMISSIONER OF THE GENERAL LAND OFFICE

THE LAND OFFICE, WASHINGTON, D. C.

TO THE SENATE AND HOUSE OF REPRESENTATIVES

IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE AND HOUSE OF REPRESENTATIVES

APRIL 1, 1873

BY THE COMMISSIONER OF THE GENERAL LAND OFFICE

AND BY THE COMMISSIONER OF THE BUREAU OF LANDS

AND BY THE COMMISSIONER OF THE BUREAU OF MINES

AND BY THE COMMISSIONER OF THE BUREAU OF GEOLOGY

AND BY THE COMMISSIONER OF THE BUREAU OF FOREST SERVICE

AND BY THE COMMISSIONER OF THE BUREAU OF FISHERY

AND BY THE COMMISSIONER OF THE BUREAU OF AGRICULTURE

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

14-655 1		72 11587		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 11587	
BIRTH NO.				STATE OF MARYLAND-DEMD			
1. NAME OF DECEASED (Type or Print)		SAMUEL D HARMON		2. DATE AND HOUR OF DEATH		DEC 4th 4.20 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
THE UNION MEMORIAL HOSP.				MARYLAND		Baltimore	
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				GARRISON		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER			
				4 MONTROSE AVENUE			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (in years last birthday)	
M	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		3-26-06		66	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
TIME KEEPER		American Totalisator		MARYLAND		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
JOSEPH M. HARMON				ETHEL MORRIS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No		220-01-4527		MRS. EVELYN HARMON		SAME	
18. 579.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
				Respiratory insuff.			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Chronic Obstructive Lung disease			
				(C) _____			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Nov 28 1972 to DEC 4 1972, that (I) (we) last saw the deceased alive on DEC 4th 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
ANDRES SUAREZ, M.D.							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		Dec. 7, 1972		Evergreen Mem. Gardens		Finksburg, Carroll, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
DEC 7 1972		Indy...		H. J. E.			



DEC 5 1913

W. H. H. H.

W. H. H. H.

W. H. H. H.



62-29-73 djr  
W-240

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

72 11588

STATE OF MARYLAND - DEPT.

BIRTH NO.

72 11588

1. NAME OF DECEASED

(Type or Print)

WASULA, JOHN

2. DATE AND HOUR OF DEATH

DECEMBER 4, 1972

6:45

A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Baltimore City Hospitals

4940 Eastern Avenue

Baltimore, Maryland

21222

4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)

A. STATE

Maryland

Baltimore

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

7605 Gum Road

21222

5. SEX

Male

6. RACE

Caucasian

7. MARRIED ☐NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

MARCH 29 1903

9. AGE (In years  
last birthday)

69

If Under 1 Yr.

Months: Days:

If Under 24 Hrs.

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

RETIRED HELPER

10B. KIND OF BUSINESS OR INDUSTRY

PITTSBURG GLASS CO

11. BIRTHPLACE (State or foreign country)

New York

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

DAVID WASULA.

14. MOTHER'S MAIDEN NAME

PELAGIO UNK.

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

212-05-9261A

17. INFORMANT

ADDRESS

4940 Eastern Avenue  
BCH: RECORDS Baltimore, Maryland 21224

18.

431.01

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

high blood pressure

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (Notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY.  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR

22. I certify that (I) (this hospital) attended the deceased from Dec 3 19 72 to Dec 4 19 72  
that (I) (we) last saw the deceased alive on Dec 4 19 72 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

MCS Cole M.D.

DEGREE

Attending  
Phys. ☒Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

December 4, 1972

23C. PHYSICIAN'S  
NAME (Type)

Mary Lee Cole, M.D.

23D. ADDRESS

Baltimore City Hospitals  
4940 Eastern Avenue Baltimore, Maryland 21224

DEGREE

24A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

24B. DATE

DEC 7 1972

24C. NAME OF CEMETERY OR CREMATORY

HOLY REDEEMER CEM.

24D. LOCATION

4430 BELAIR RD BALTO MD.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

DEC 7 1972

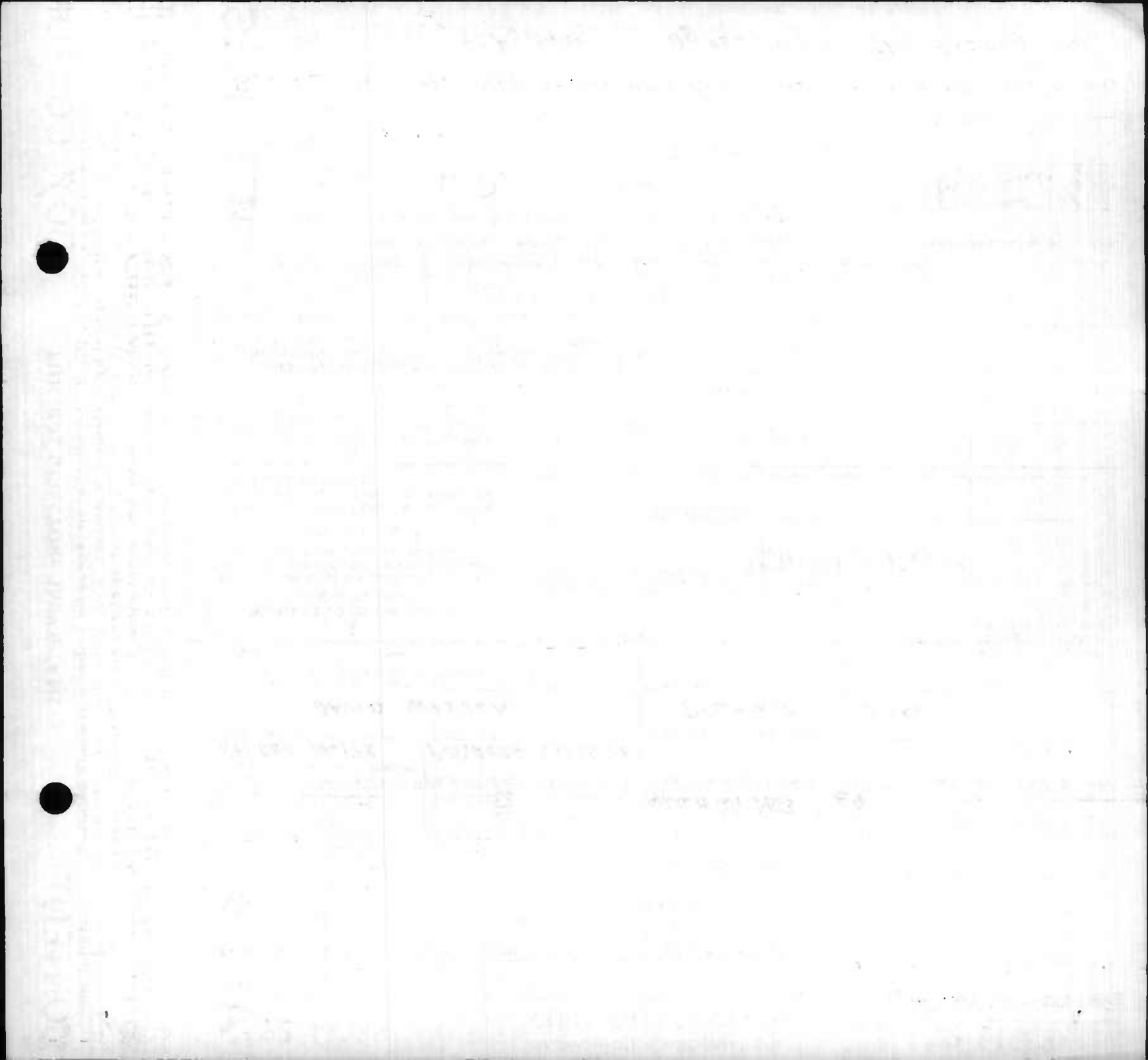
25B. NAME OF REGISTRAR

Sidney [Signature]

25C. FUNERAL DIRECTOR

DIPREL BROS INC 7810 BELAIR RD.

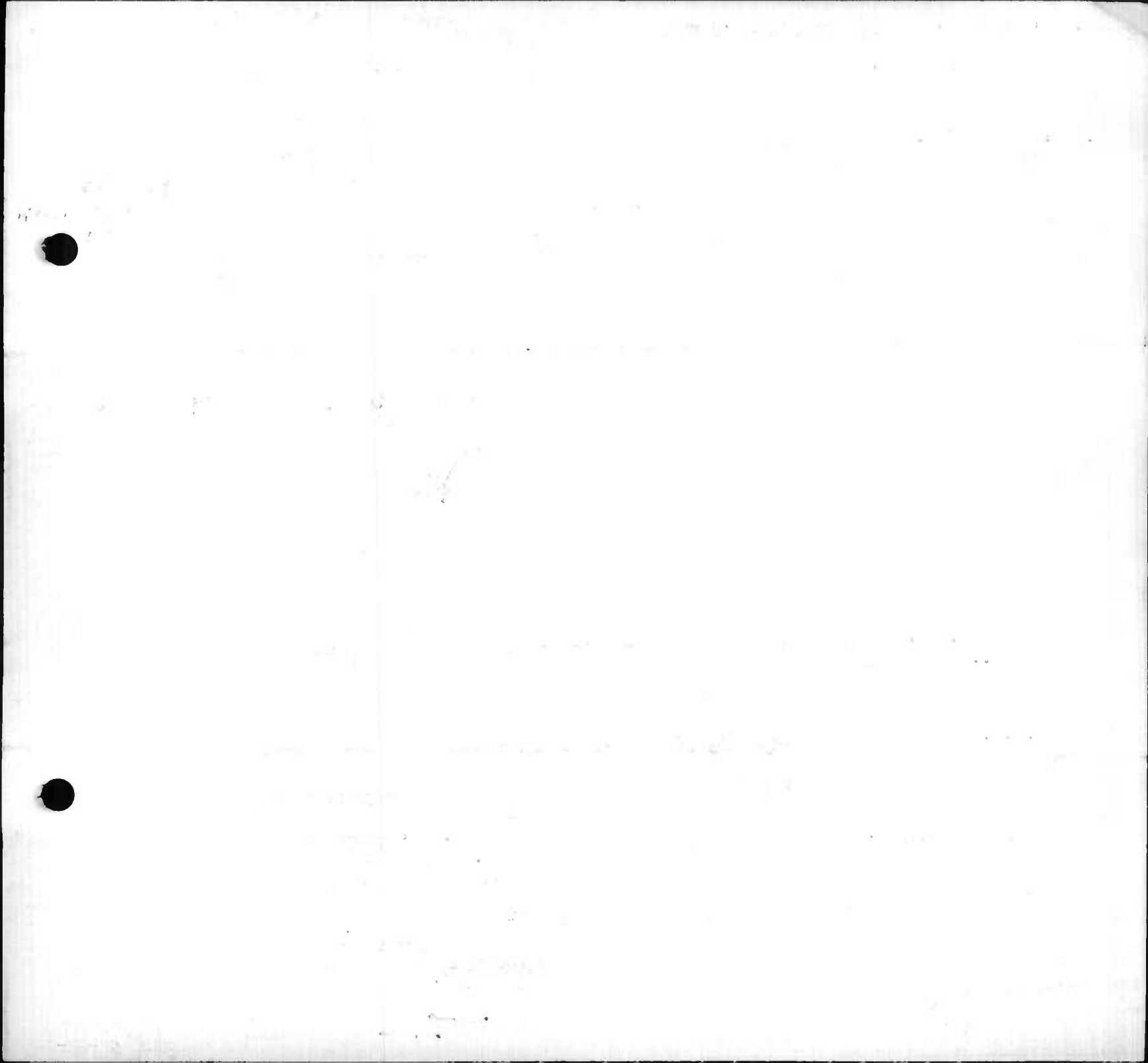
ADDRESS



Released By Med. Examiner  
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

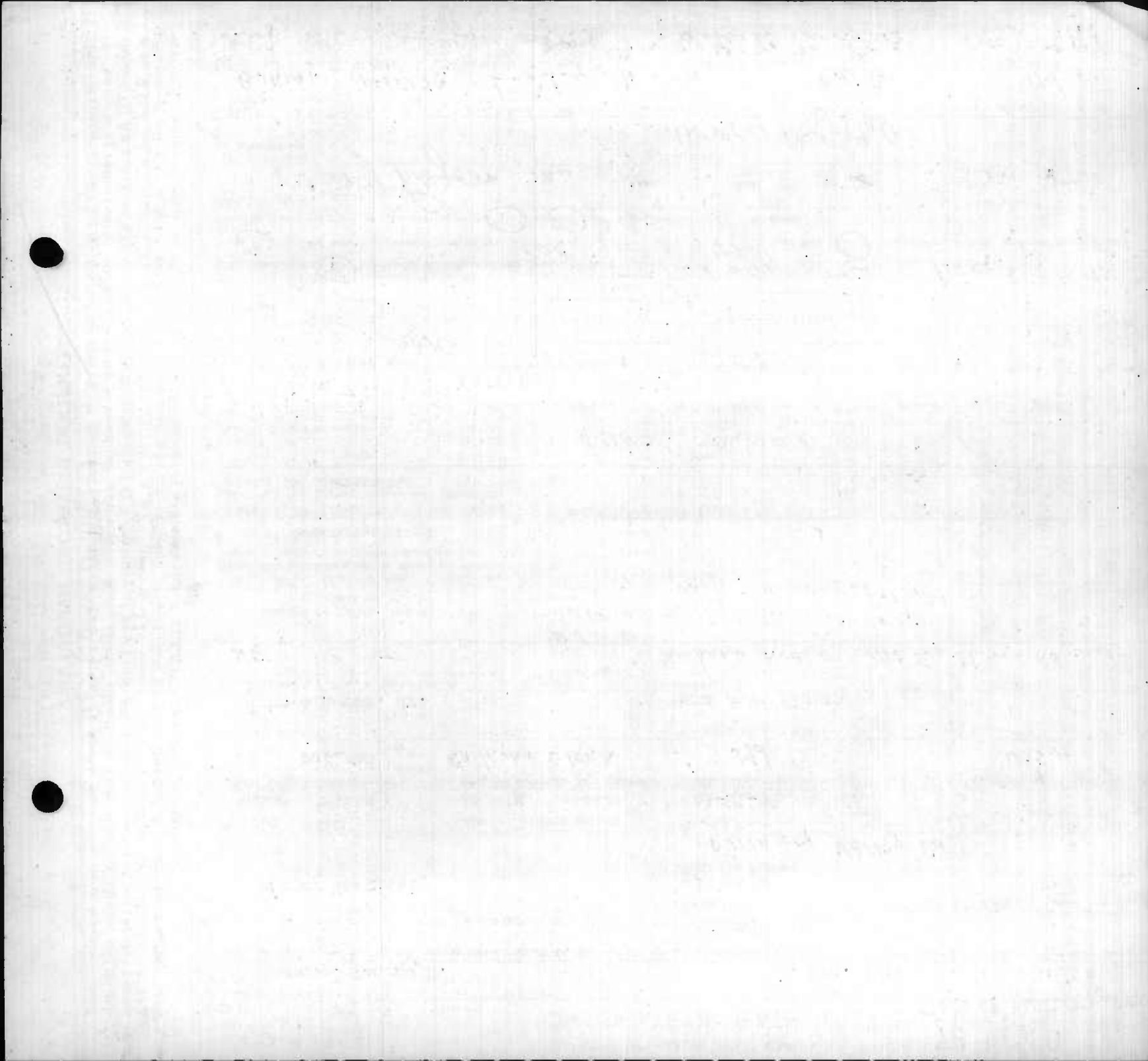
72 11589		BALTIMORE CITY HEALTH DEPARTMENT		72 11589	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>George A. Anderson</b>		2. DATE AND HOUR OF DEATH <b>12/2/72 6 PM</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>31 Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md. 21224</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Dundalk</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>7471 Berkshire Rd. 21224 005</b>			
5. SEX <b>Male</b>	6. RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/26/99</b>	9. AGE (In years last birthday) <b>73</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Beth. Steel Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME <b>Christina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>National Guard</b>		16. SOCIAL SECURITY NO. <b>174-07-9727-A</b>		17. INFORMANT <b>BCH Records: Baltimore, Md. 21224</b>	
18. <b>4124 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ASCVD</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <b>ASCVD</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cardio-vascular disease</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>XXXXXX</b> (C) DUE TO, OR AS A CONSEQUENCE OF: <b>XXXXXX</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<b>Pulmonary Emphysema</b>		<b>Rev. 5/72</b>	
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Dec. 2, 1972</b> to <b>Dec. 2, 1972</b> that (I) (we) last saw the deceased alive on <b>Dec. 2, 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>D. E. McEntone, M.D.</b>		23B. DATE SIGNED <b>12/2/72</b>		23C. PHYSICIAN'S NAME (Type) <b>Jay E. McEntone, M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-5-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Bel Air Memorial Gardens</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 7 1972</b>		25B. NAME OF REGISTRAR <b>Sidney Ingham</b>		25C. FUNERAL DIRECTOR <b>John J. Duda</b>	
24D. LOCATION (City, town, or county) <b>Bel Air, Maryland</b>		24E. ADDRESS <b>4940 Eastern Ave. Baltimore, Md.</b>		24F. ADDRESS <b>7922 Wise Ave. Dundalk, Md. 21222</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 11590	
72 11590				STATE OF MARYLAND-DEMD	
BIRTH NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Reese, George H.</b>				3, Dec. 1972 - 3:40 a. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <b>Mercy Hospital</b>				A. STATE <b>Maryland</b>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				B. COUNTY <b>BALTO</b>	
C. CITY OR TOWN <b>Baltimore</b>				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER <b>DULLANEY Valley Rd.</b>					
5. SEX <b>male</b>	6. RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-01-86</b>	9. AGE (In years last birthday) <b>86</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Railroad CLERK</b>		11. BIRTHPLACE (State or foreign country) <b>Md</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>					
13. FATHER'S NAME <b>John A Reese, Jr.</b>				14. MOTHER'S MAIDEN NAME <b>Emma Jane Wiggan</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Richard Reese</b>	
				ADDRESS <b>411 Ivy Church Rd 21093</b>	
18. <b>I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of HEAD OF PANCREAS</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Renal Failure</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Renal Failure</b>					
19A. DATE OF OPERATION <b>124 NOV 72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>carcinoma PANCREAS</b>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>NOV 20</b> 19 <b>72</b> to <b>Dec 3</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>Dec 3</b> 19 <b>72</b> and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Victor J. Rogerson, MD</b>				23B. DATE SIGNED <b>3 Dec, 1972</b>	
23C. PHYSICIAN'S NAME (Type) <b>Victor J. Rogerson</b>				23D. ADDRESS <b>Mercy Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12/5/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>LONDON PK Cem</b>	
24D. LOCATION <b>BALTO</b>		24E. STATE <b>Md</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 7 1972</b>		25B. NAME OF REGISTRAR <b>Richard H. Hooton</b>		25C. FUNERAL DIRECTOR <b>Michael W. Redfield</b>	
				ADDRESS <b>6500 York Rd</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 11591		72 11591	
CERTIFICATE OF DEATH				STATE OF MARYLAND-DEME			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
		SHALCOSKY STANLEY		Dec. 4 '72		11:45 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE MO. 8			
South Baltimore General Hospital				C. CITY OR TOWN Baltimore			
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER 1519 Church Street			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
male	white	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	May 8 '99	73	Warehouse	Poland	Poland
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Joseph				Katherine			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT			
NO		218-10-3826		Mrs. Anna Prieko 1607 South Clarence Ave. Berwyn Illinois.			
18. CAUSE OF DEATH				ADDRESS			
18.4 27.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				Congestive heart failure.			
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				No			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Nov. 7 1972 to Dec. 4 1972 that (I) (we) last saw the deceased alive on Dec. 4 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Chang				23B. DATE SIGNED Dec 4, '72			
23C. PHYSICIAN'S NAME (Type) J. S. CHANG, MD				23D. ADDRESS South Baltimore General Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		12-7-72		HOLY CROSS		RITCHIE HWY BALTO MD	
25A. DATE REC'D BY HEALTH DEPT. DEC 7 1972		25B. NAME OF REGISTRAR Sidney W. ...		25C. FUNERAL DIRECTOR HOME FUNERAL Home		ADDRESS 4200 Pennington	



DEPT. OF AGRICULTURE

UNITED STATES

1915

1915

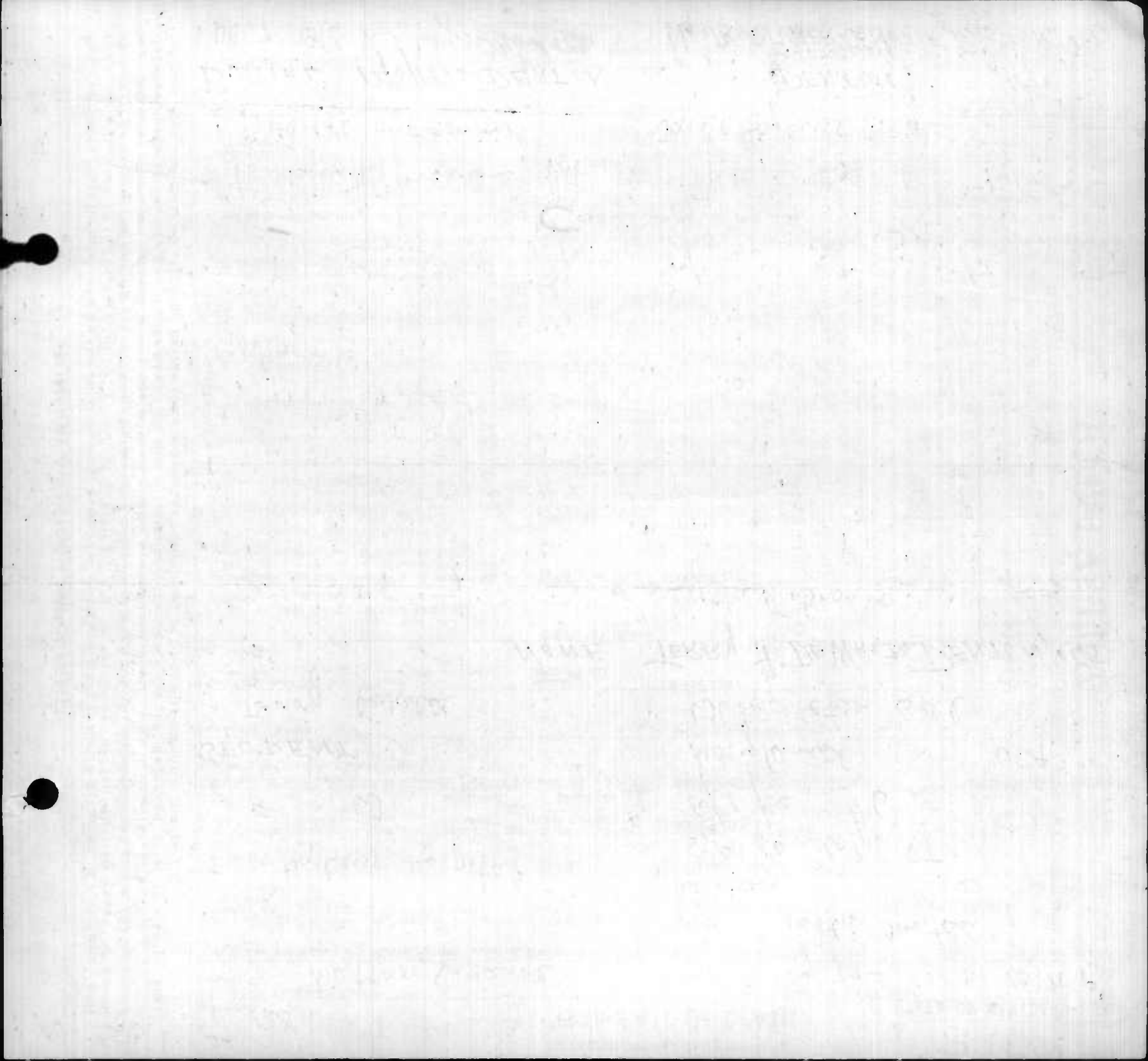
1915

1915

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

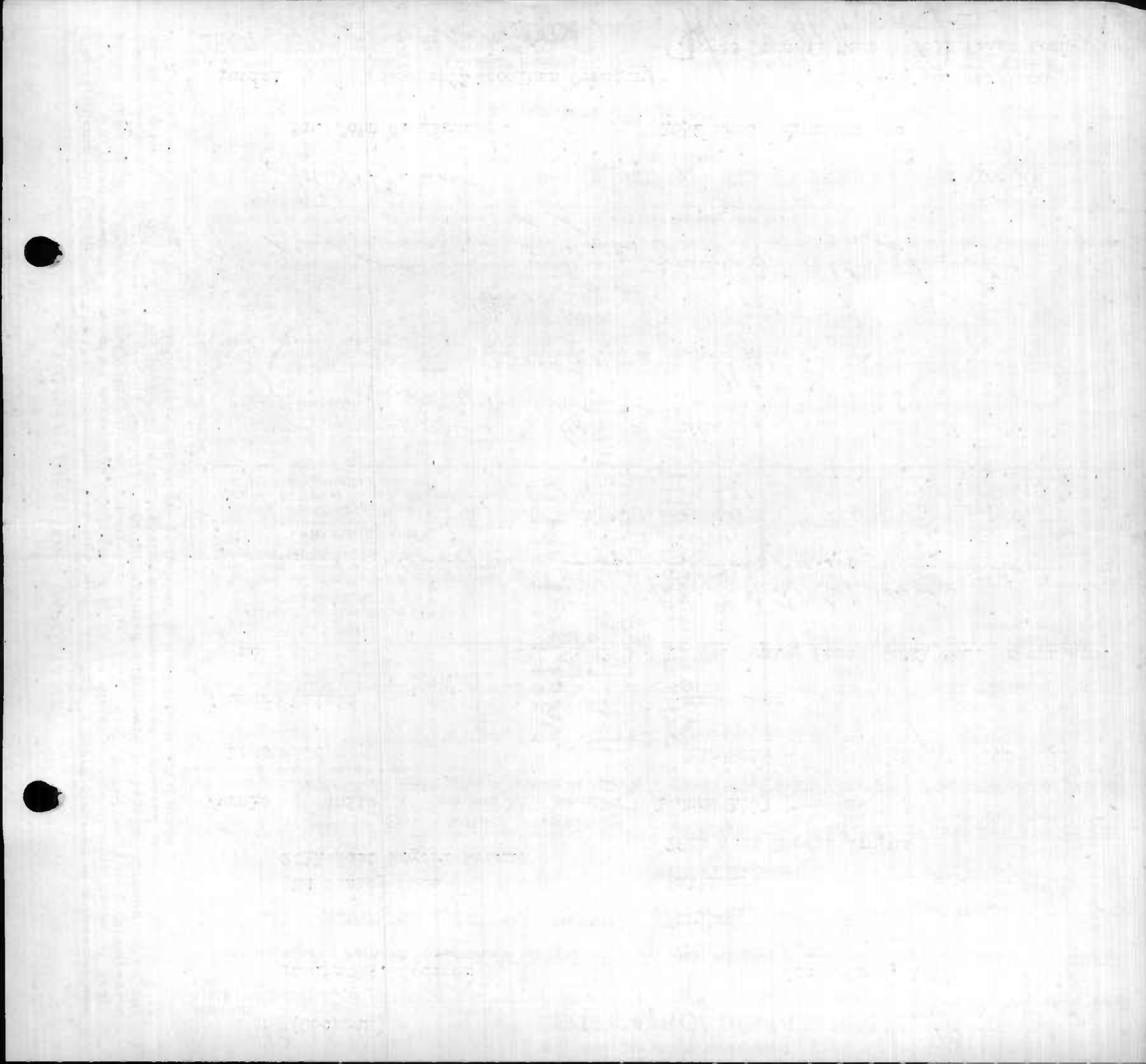
M-320 1		Dalbert Co. 66-35147 72 11592		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 11592	
BIRTH NO.				STATE OF MARYLAND-DEMH			
1. NAME OF DECEASED (Type or Print) <u>Mattox, Suzanne</u>				2. DATE AND HOUR OF DEATH <u>12/4/72</u> <u>10:15 P</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Johns Hopkins Hospital</u>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Penton</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>509 Randolph ST.</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/1/68</u>	9. AGE in years last birthday <u>6</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STUDENT</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Terry DeWald</u>			
14. MOTHER'S MAIDEN NAME <u>Wheedleton, Gail</u>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>NONE</u>				17. INFORMANT <u>TERRY A. DEWALD DENTON, MD.</u>			
18. <u>223.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Cystic Fibrosis</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <u>12/4/72</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) <u>No</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6y</u>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Indify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>12/1/72</u> 19 <u>72</u> to <u>12/4/72</u> 19 <u>72</u> , that (I) <u>(we)</u> lost saw the deceased alive on <u>12/4/72</u> 19 <u>72</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> (did not) view the body after death.							
23A. SIGNATURE <u>Thomas Hoffman</u>				23B. DATE SIGNED <u>12/4/72</u>			
23C. PHYSICIAN'S NAME (Type) <u>THOMAS HOFFMAN</u>				23D. ADDRESS <u>Johns Hopkins Hosp</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>				24B. DATE <u>12/8/1972</u>			
24C. NAME OF CEMETERY or CREMATORY <u>DENTON</u>				24D. LOCATION (City, town, or county) (State) <u>DENTON, MD.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 7 1972</u>				25B. NAME OF REGISTRAR <u>Sidney Whitford</u>			
25C. FUNERAL DIRECTOR <u>NEW YORK FUNERAL HOME, EASTON, MD.</u>				25D. ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 11593</u>	
C-265 1				72 (Cochran)	
BIRTH NO.				STATE OF MARYLAND-DEMD	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
<u>Pauline E. Cochran</u>			<u>December 2, 1972</u>   <u>9:55 P</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>90 The Wesley Home</u> <u>2211 West Rogers Avenue</u>			A. STATE <u>Maryland</u> B. COUNTY <u>2755</u>		
			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>2211 West Rogers Avenue</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1 June 1883</u>	9. AGE (In years last birthday) <u>89</u>	10. Under 1 Yr. Months: Days If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>Usa</u>
13. FATHER'S NAME <u>Edward Wright</u>			14. MOTHER'S MAIDEN NAME <u>Sarah Page</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>218 54 4298</u>	17. INFORMANT ADDRESS <u>J 1 The Wesley Home 2211 West Rogers Ave.</u>		
18. <u>412.4 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Arterio-sclerotic Cardiovascular Disease</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Osteo arthritis</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>25 January 1969</u> to <u>2 December 1972</u> , that (I) (we) last saw the deceased alive on <u>50 November 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>John W. Barnaby</u>			23B. DATE SIGNED <u>5 Dec 72</u>		
23C. PHYSICIAN'S NAME (Type) <u>Dr. John W. Barnaby</u>			23D. ADDRESS <u>1652 East Belvedere Ave</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5 Dec 1972</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Co. Maryland</u>
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 7 1972</u>		25B. NAME OF REGISTRAR <u>Audrey H. H. H. H.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Burgess Funeral Home 3631 Falls Road</u>	



1  
B-630

72 11594

BALTIMORE CITY HEALTH DEPARTMENT

72 11594

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

STATE OF MARYLAND-DHMH

1. NAME OF DECEASED (Type or Print) CATHERINE BARRETT		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 4323 Falls Road		3. DATE PRONOUNCED DEAD Month Day Year December 2, 1972 3:05 P. M.	
6. SEX Female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2714	
9. DATE OF BIRTH July 6 1884		10. AGE (In years last birthday) 88	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 216 05 7847	
18. INFORMANT Margaret E. Shade		ADDRESS 3705 Roland Ave	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <u>Ronald N. Kornblum</u> M.D. Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/3/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6 Dec 72	
24C. NAME of CEMETERY or CREMATORY Jessops Cemetery		24D. LOCATION (City, town, or county) (State) Cockeysville, Ba to Co Md	
25A. DATE REC'D BY HEALTH DEPT. DEC 7 1972		25B. NAME OF REGISTRAR Sidney [Signature]	
25C. FUNERAL DIRECTOR Lungee Funeral Home, Baltimore Maryland		ADDRESS [Signature]	



1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951



B-400

1

72 11595

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 11595

BIRTH NO.

STATE OF MARYLAND-DEME

REG. NO.

1. NAME OF DECEASED (Type or Print) HAYWARD L. BAILEY		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2015 St. Paul Street		3. DATE PRONOUNCED DEAD Month Day Year Hour December 2, 1972 1:45 P. M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 3 Sept 1925		10. AGE (in years lost birthday) 47	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Messenger		14B. KIND OF BUSINESS OR INDUSTRY Courier Co.	
15. MOTHER'S MAIDEN NAME Annie L. Justice		16. INFORMANT ADDRESS Hayward L. Bailey 1338 W. 37th Street	
17. SOCIAL SECURITY NO. 220 12 4890		18. INFORMANT ADDRESS Hayward L. Bailey 1338 W. 37th Street	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Apoplectic Hematoma of Pons (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hypertensive cardiovascular disease (B) DUE TO, OR AS A CONSEQUENCE OF: (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 12/6/72		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		22G. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE [Signature] Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/3/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/6/72	
24C. NAME of CEMETERY or CREMATORY Woodlawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Co, Maryland	
25A. DATE REC'D BY HEALTH DEPT DEC 7 1972		25B. NAME OF REGISTRAR Sidney H. [Signature]	
25C. FUNERAL DIRECTOR Burgee Funeral Home		25D. ADDRESS 3631 Falls Road	

11-11-11

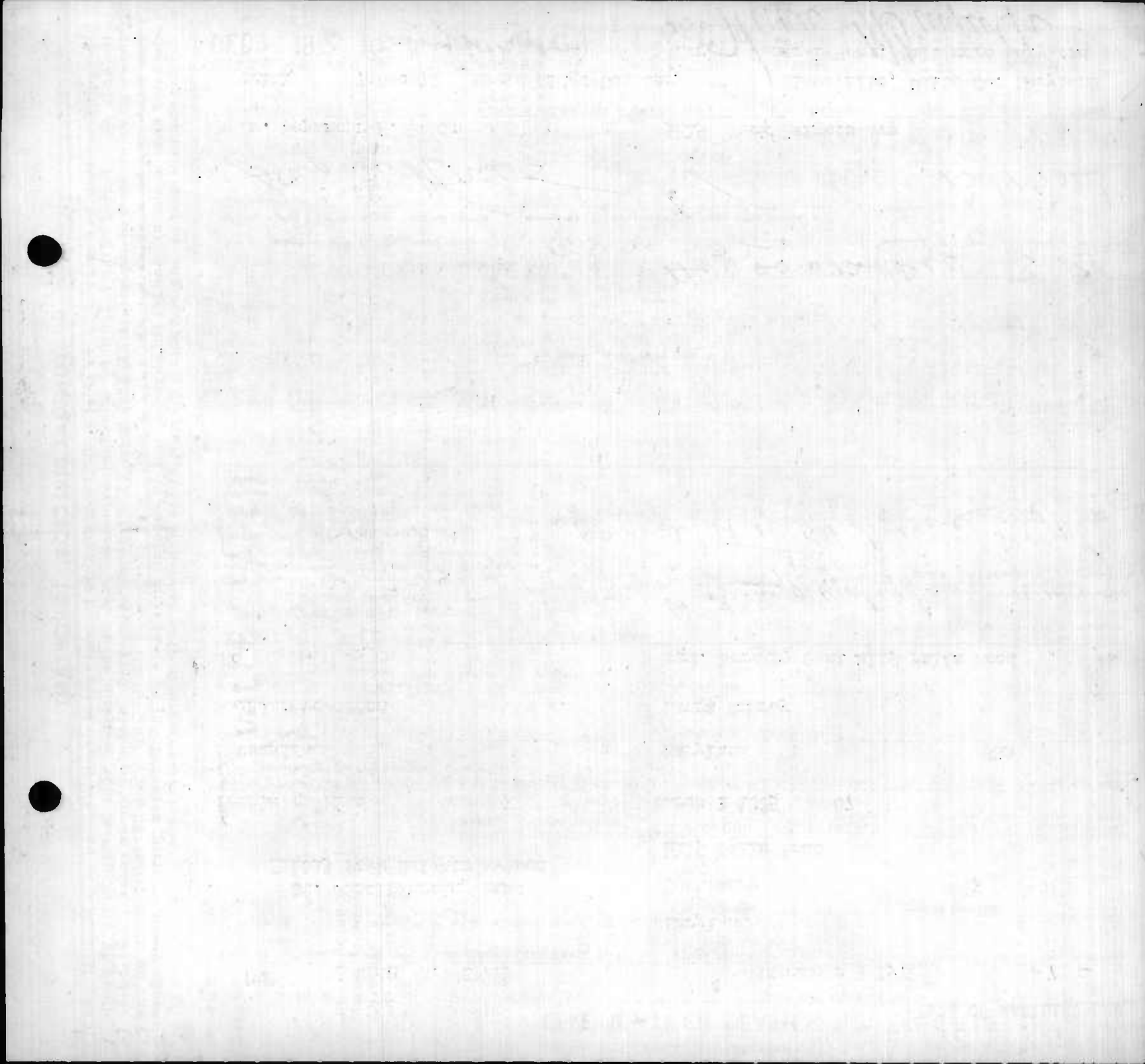
11-11-11

11-11-11

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 11596	
72 11596				STATE OF MARYLAND-DEHE	
BIRTH NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>BEULAH M. SPANN</b>			December 3 1972 7 a M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>90 Mt. Sinai Nursing Home 4613 Park Heights Avenue</b>			A. STATE <b>Maryland</b> B. COUNTY <b>2714</b>		
			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>4119 Falls Road</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 1 1885</b>	9. AGE (In years last birthday) <b>87</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>William McFadden</b>		14. MOTHER'S MAIDEN NAME <b>Laura Henroy</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Mrs. Dorothy Gent 4119 Falls Road</b>	
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <b>Acute myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b> <b>Several years</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Nov 29 1972</b> to <b>Dec 3 1972</b> , that (I) (we) last saw the deceased alive on <b>Nov 29 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Seymour H. Rubin</b> DEGREE				23B. DATE SIGNED <b>12/4/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Seymour H. Rubin</b> DEGREE				23D. ADDRESS <b>5415 Park Heights Ave</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7 Dec 72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Pikesville, Balto Co. Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 7 1972</b>		25B. NAME OF REGISTRAR <b>Dr. Seymour H. Rubin</b>		25C. FUNERAL DIRECTOR <b>Bureau Funeral Home, Baltimore Maryland</b>	



K-460 1

72 11597 (Bertha)

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 72 11597

STATE OF MARYLAND-DEHM

BIRTH NO.

1. NAME OF DECEASED

(Type as Print)

KELLER, BERTHA E

2. DATE AND HOUR OF DEATH

12-03-72 7:05 PM

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)THE (600) SAMARITAN HOSPITAL  
45

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

4302 GRANDVIEW AVE.

5. SEX

F

6. RACE

W

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

12-01-14

9. AGE (In years  
last birthday)

58

If Under 1 Yr.

Months Days

If Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

-

11. BIRTHPLACE (State or foreign country)

Md

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

WINE, LOUIS

14. MOTHER'S MAIDEN NAME

SULLIVAN, BESSIE

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

217-265662

17. INFORMANT

Ellsworth L Keller

ADDRESS

Seymour

18. 5-77X1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Acute Pulmonary Embolism

10 hours.

(B) DIFFUSE INTERSTITIAL PULMONARY FIBROSIS

DUE TO, OR AS A CONSEQUENCE OF:

3 years.

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

Congestive heart failure

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

No

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (1) (this hospital) attended the deceased from 12/3 1972 to 12/3 1972  
that (1) (we) last saw the deceased alive on 12/3 1972 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Eugene J. Burdige, M.D.

DEGREE

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

12/3/72

23C. PHYSICIAN'S  
NAME (Type)

Eugene J. Burdige, M.D.

DEGREE

23D. ADDRESS

Johns Hopkins Hospital

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

7 Dec 72

24C. NAME OF CEMETERY OR CREMATORY

Lorraine Park Cem

24D. LOCATION

(City, town, or county)

(State)

Woodlawn Bk/Ho Co Md

25A. DATE REC'D BY HEALTH DEPT.

DEC 7 1972

25B. NAME OF REGISTRAR

Audrey H. Heston

25C. FUNERAL DIRECTOR

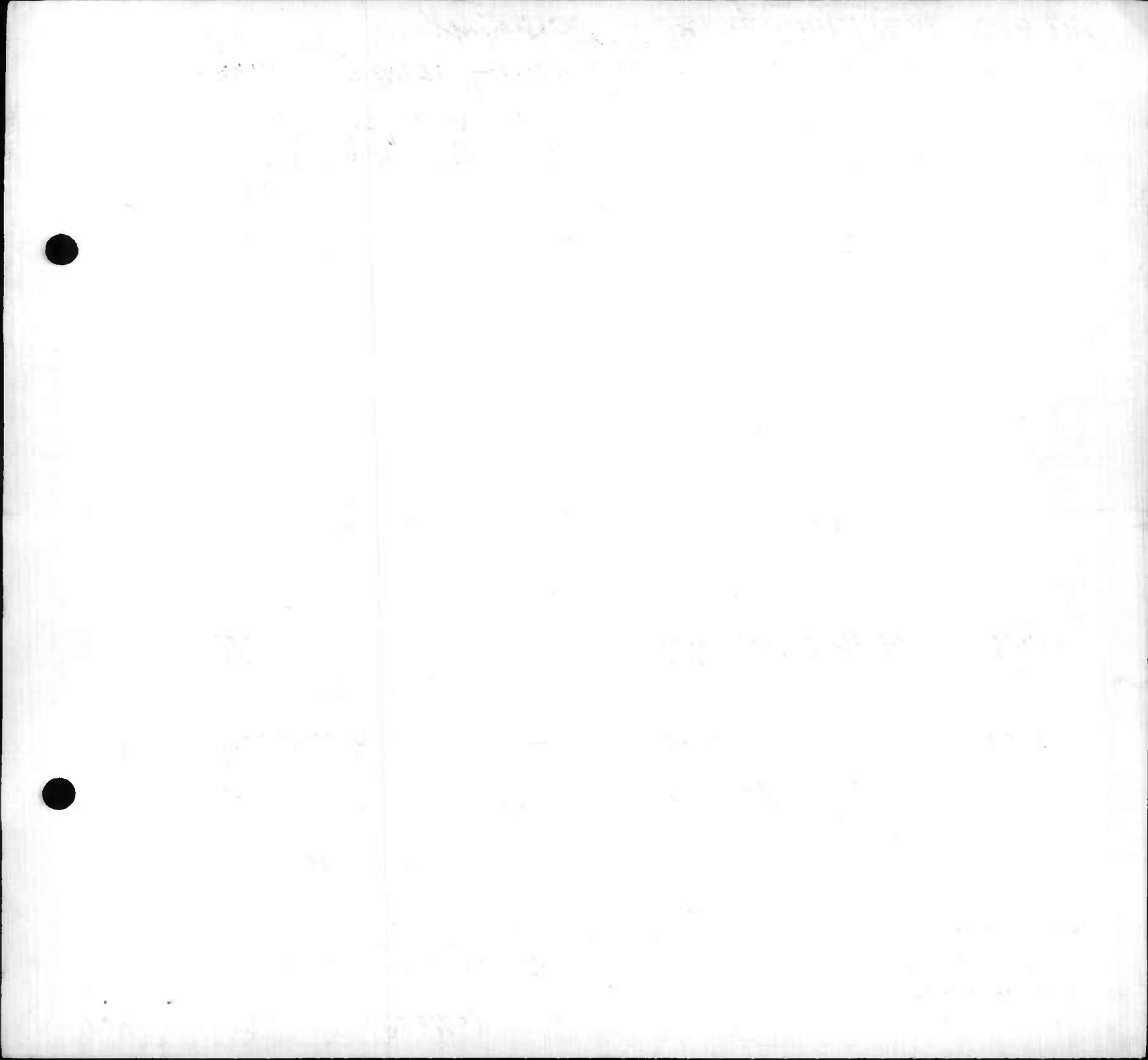
Burdige Funeral Home

ADDRESS

Bk/Ho Md

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.





1  
W-256

72 11598

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 11598

BIRTH NO.

STATE OF MARYLAND - DEATH

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>Francis GEORGE WISNER</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Union Memorial Hospital (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>12 3 1972 11:48p</b>	
6. SEX <b>male</b>		7. RACE <b>white</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>1306</b>	
9. DATE OF BIRTH <b>Nov 20 1916</b>		10. AGE (In years last birthday) <b>55</b> If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Draftsman</b>	
15. MOTHER'S MAIDEN NAME <b>Bertha ?</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WWII</b>	
17. SOCIAL SECURITY NO. <b>213 03 7353</b>		18. INFORMANT ADDRESS <b>Thelma T. Wisner 3648 Hickory Avenue</b>	
19. <b>8821X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Multiple injuries</b>		CAUSE OF DEATH <b>Multiple injuries</b>	
20. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>no</b>		22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.) <b>bridge</b>		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>41st Street bridge</b>	
22D. TIME OF INJURY (APPROX.) <b>12-3-72 11:22p</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? <b>Fell from bridge.</b>		23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
NAME (Type) <b>Ronald N. Kornblum, M.D.</b>		Deputy Chief Medical Examiner <b>12-4-72</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7 Dec 1972</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mays Chapel Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Co, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 7 1972</b>		25B. NAME OF REGISTRAR <b>Sidney [Signature]</b>	
25C. FUNERAL DIRECTOR <b>Burpee Funeral Home, Baltimore, Maryland</b>		25D. ADDRESS <b>6-7 [Signature]</b>	



10/11/70

Page 10 of 10

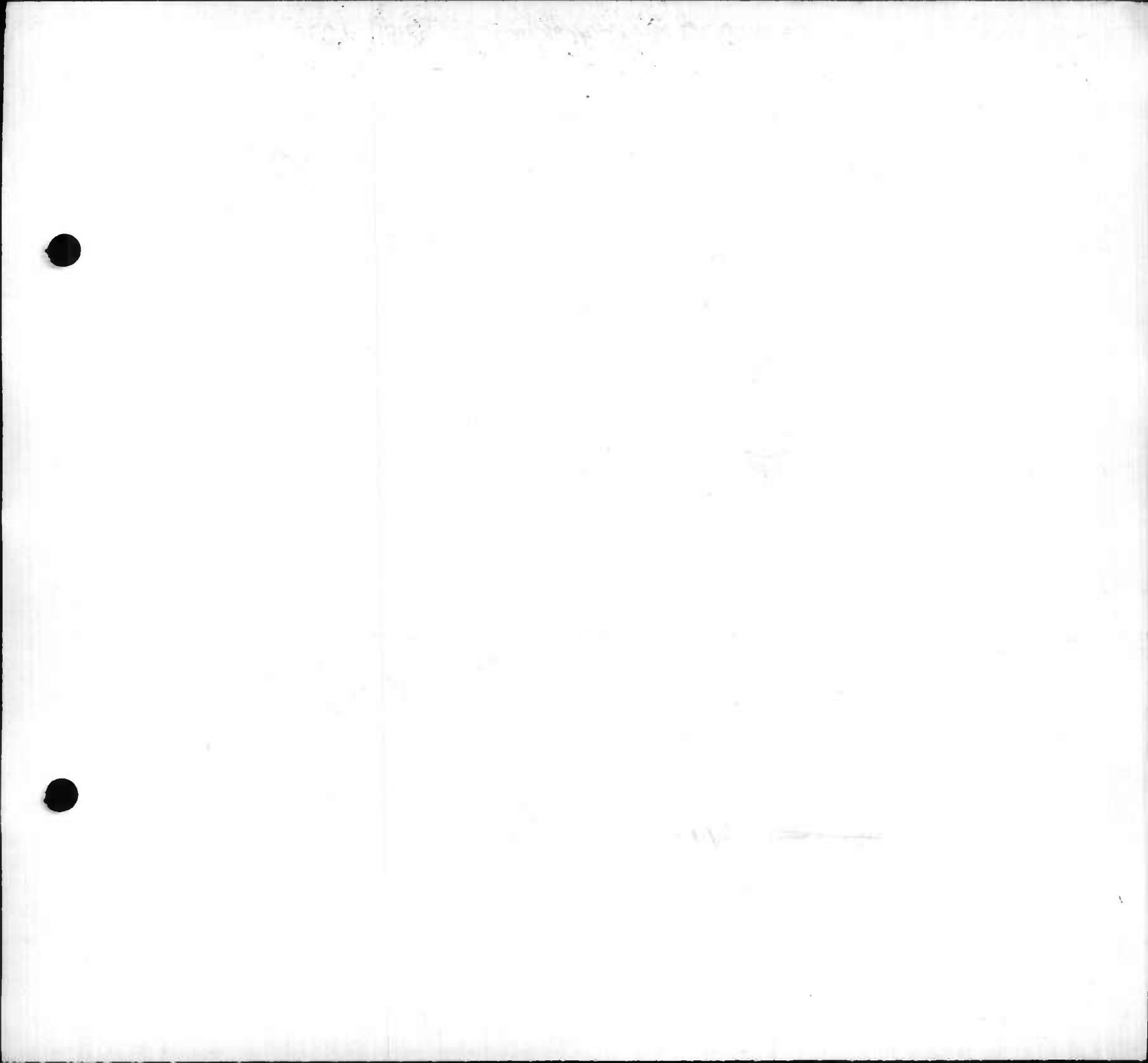
Page 10 of 10

10/11/70

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 11599		REG. NO. 72 11599	
CERTIFICATE OF DEATH				STATE OF MARYLAND-DHMH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
		FALLIN LEVI		12-5-72 18:30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  +6 LUTHERAN HOSPITAL				A. STATE		B. COUNTY	
				MARYLAND		1547	
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				3144 WINDSOR AVE.			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?	
M	NEGRO	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	5/24/1919		53	U.S.A	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Bookbinder				Albert Co		MARYLAND	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Charles Fallin				Cora Lee Palmer			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
Yes		W.W. II		224-12-0415 ARNETTA - WIFE		SAME	
18. 013.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				Tuberculous MENINGITIS - 2-3 days			
ANTECEDENT CAUSES				(B) Pneumonia		2 days	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) 62d - Cerebrovascular		4 months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				Accident			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		White At <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 12-4-1972 to 12-5-1972 that (I) (we) last saw the deceased alive on 12/5-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Renato A. Labog M.D.				12-5-72			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS					
Renato A. Labog M.D.		LUTHERAN HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		12-9-72		Arbutus Mem Park		Arbutus Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
DEC 7 1972		Audrey Ingham		2222 w north ave			



56-12-65 h1

BALTIMORE CITY HEALTH DEPARTMENT

72 11600

## CERTIFICATE OF DEATH

REG. NO. 72 11600

STATE OF MARYLAND-DEMH

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

James, Ernest

2. DATE AND HOUR OF DEATH

December 4, 1972

8:00 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)1 Baltimore City Hospital  
4940 Eastern Avenue, Baltimore, Md. 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Baltimore, Maryland

808

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

1015 N. Broadway

5. SEX

Male

6. RACE

Negro

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

10/25/32

9. AGE (In years  
lost birthday)

40

If Under 1 Yr.

Months Days

If Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Orderly

10B. KIND OF BUSINESS OR INDUSTRY

Sinal Hosp

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Mitchell

14. MOTHER'S MAIDEN NAME

Idell

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

BCH Records 4940 Eastern Avenue, Baltimore, Md.  
21224

18.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Cardiopulmonary arrest

2 hrs

(B) CHRONIC DISEASE

DUE TO, OR AS A CONSEQUENCE OF:

Chronic renal dialysis + peritonitis

1 week

(C) RECENT DISEASE

Rejected kidney transplant

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

Congestive caln necrotic

1 1/2 weeks

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

00-00

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from November 19 19 72 to December 4 19 72,  
that (I) (we) lost saw the deceased alive on 8:00 P.M. December 4, 19 72 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

David V. Wray M.D.

DEGREE

Attending  
Phys. ☐Med.  
Director ☐Stat. ☒  
Phys. ☐

23B. DATE SIGNED

12/4/72

23C. PHYSICIAN'S  
NAME (Type)

David V. Wray M.D.,

DEGREE

23D. ADDRESS

Baltimore City Hospitals

4940 Eastern Ave. Baltimore, Md. 21224

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

12/9/72

24C. NAME OF CEMETERY or CREMATORY

Mt. Calvary

24D. LOCATION

(City, town, or county)

(State)

G.A. County, Md

25A. DATE REC'D BY HEALTH DEPT.

DEC 7 1972

25B. NAME OF REGISTRAR

Audrey W. Wray

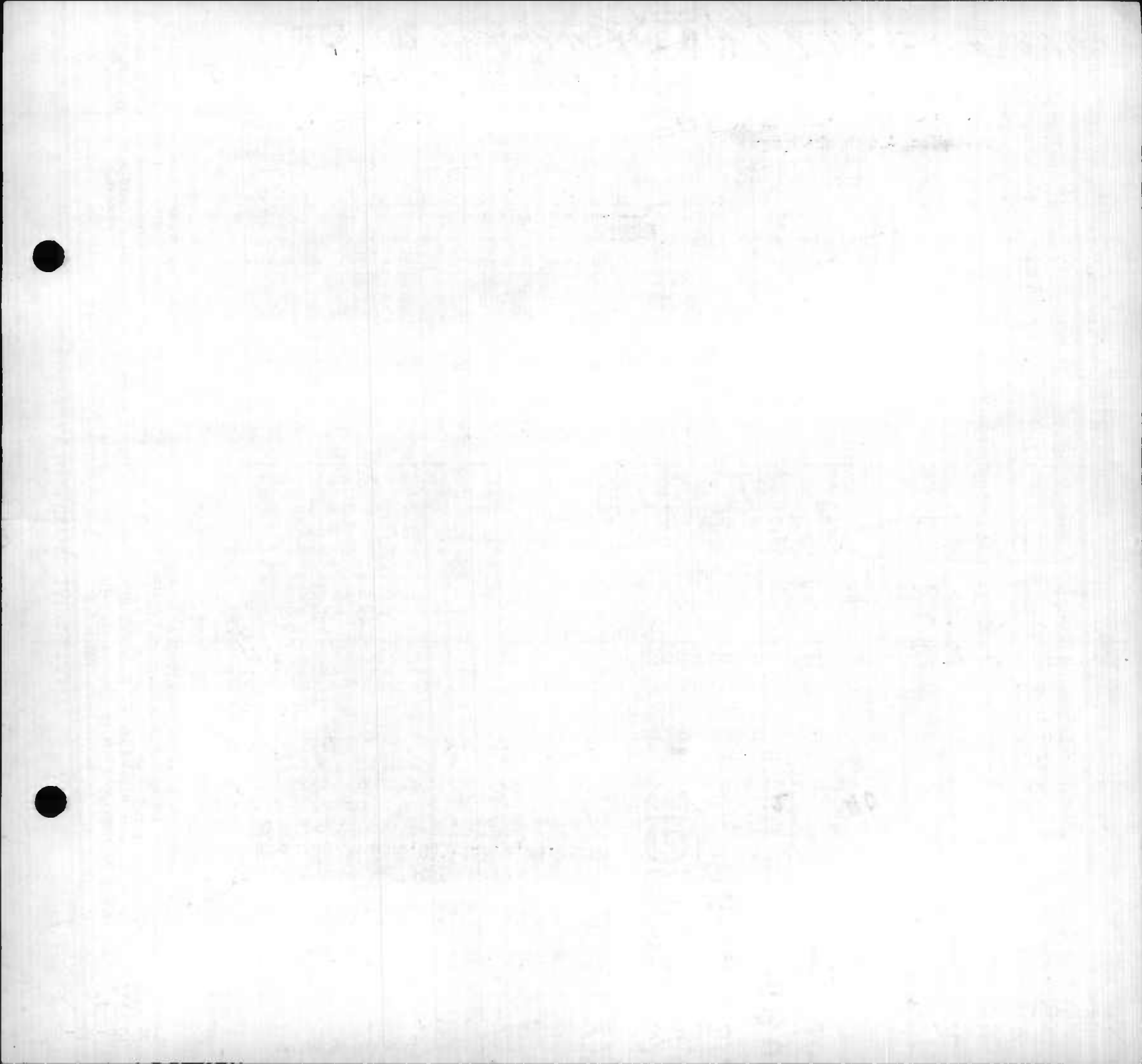
25C. FUNERAL DIRECTOR

Joseph B. Roth 1304 N. Central Ave

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



5-363

BALTIMORE CITY HEALTH DEPARTMENT

72 11601 CERTIFICATE OF DEATH

REG. NO.

72 11601

STATE OF MARYLAND-DMH

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Satterwhite, Baily AKA Satterwaite

2. DATE AND HOUR OF DEATH

12-6-72

11242 AM

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)Provident Hospital, Inc.  
2600 Liberty Height Ave.  
Baltimore, Md. 21215

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
Maryland

B. COUNTY

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

2220 West North Avenue

5. SEX

Male

6. RACE

Black

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

08-11-12

9. AGE (In years  
last birthday)

60

If Under 1 Yr.  
Months: Days: Hours: Min.If Under 24 Hrs.  
Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Receiving Clerk

10B. KIND OF BUSINESS OR INDUSTRY

Reacts Drug Store

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Willie Satterwaite

14. MOTHER'S MAIDEN NAME

Lillie Royster

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

225-16-5177

17. INFORMANT

Mrs. Bessie Satterwhite (wife)

ADDRESS

same

18.

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

INFARCTION

(B) ARTERIOSCLEROTIC &amp; HYPERTENSIVE

DUE TO, OR AS A CONSEQUENCE OF:

CARDIOVASCULAR DISEASE

(C)

not known.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

NONE

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from NOVEMBER 30 1972 to DECEMBER 6 1972  
that (I) (we) last saw the deceased alive on DECEMBER 6 1972 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

C. Custodio, M.D.

DEGREE

Attending ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

12/6/72

23C. PHYSICIAN'S  
NAME (Type)

C. CUSTODIO M.D.

DEGREE

23D. ADDRESS

PROVIDENT HOSPITAL, BALTIMORE, MD.

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

12-9-72

24C. NAME OF CEMETERY or CREMATORY

Caryer Mem Park

24D. LOCATION

Laurel

(City, town, or county)

(State)

MD

25A. DATE REC'D BY HEALTH DEPT.

DEC 7 1972

25B. NAME OF REGISTRAR

Sidney H. Heston

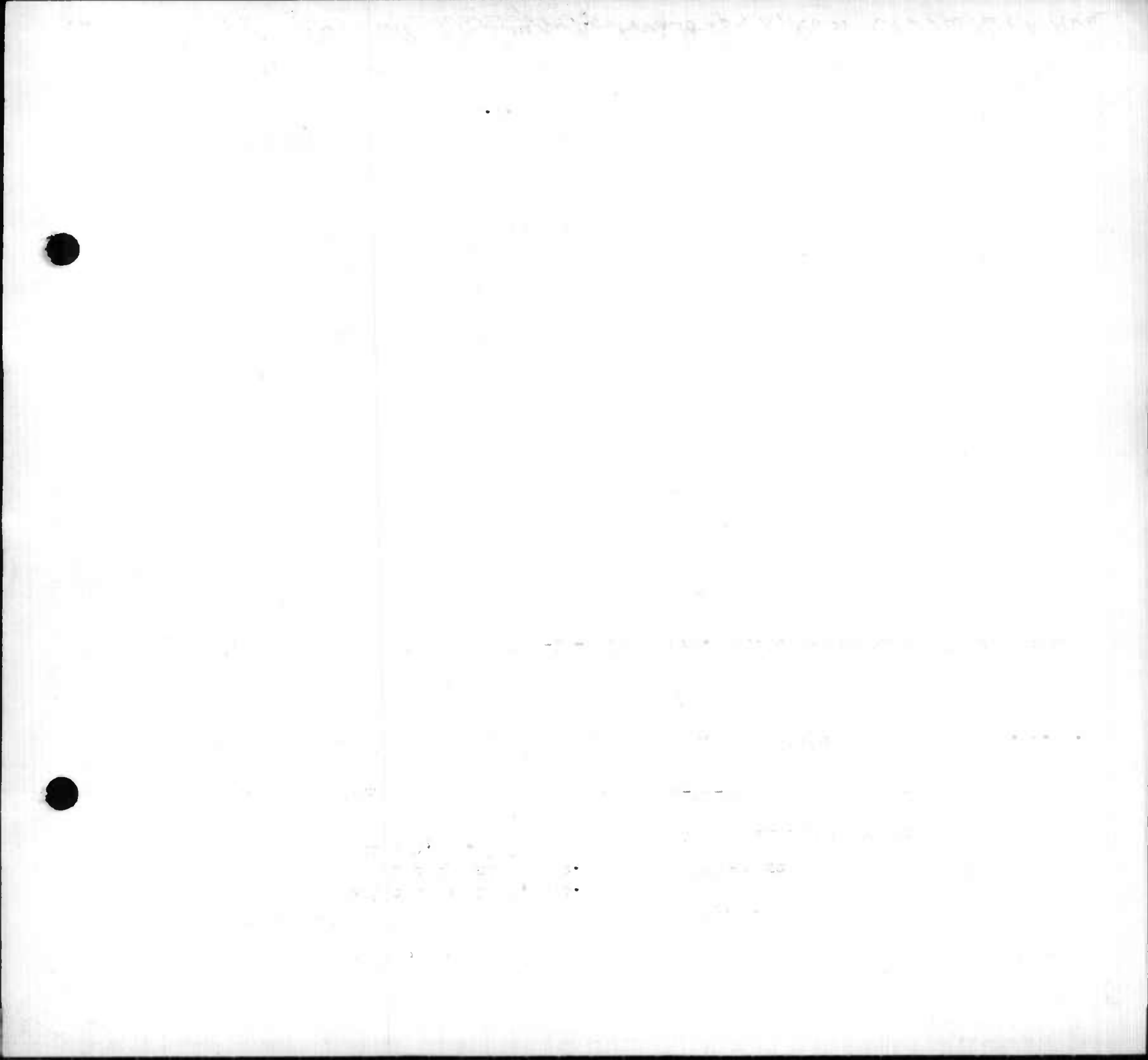
25C. FUNERAL DIRECTOR

Joseph H. Russ 2220 North Ave

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

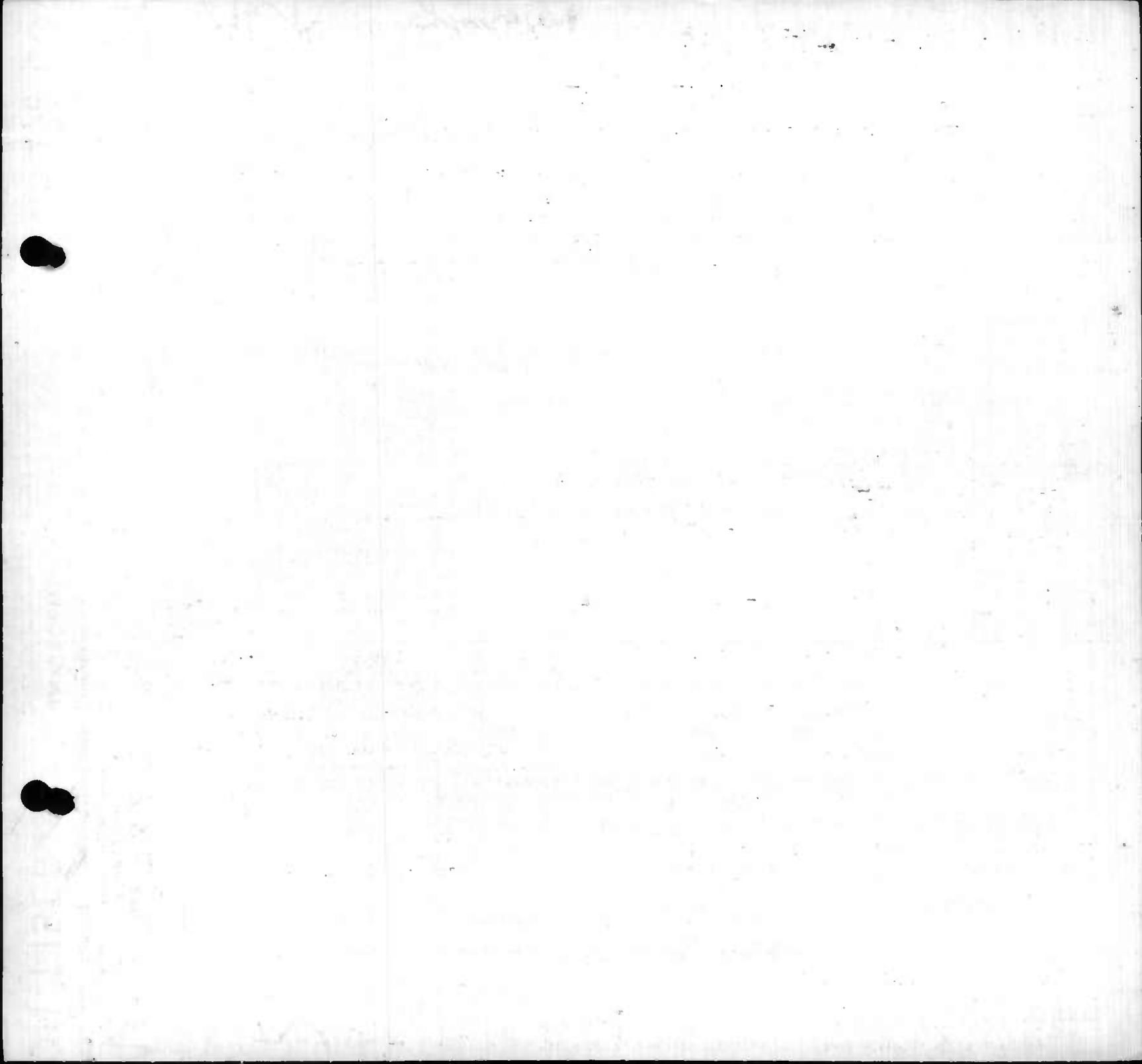
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 11602	
72 11602					
CERTIFICATE OF DEATH					
STATE OF MARYLAND-DEMH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Joseph W. Clautice		Dec. 6, 1972 330 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
37 Mercy Hospital			Maryland		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			1109 Ramblewood Road 21212		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
M	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	12-28-1906	65	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Ret'd. Secretary Association of Commerce			Baltimore, Maryland		USA
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
William Clautice			Elizabeth Kroeger		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes WWII		213-03-2965		Mrs. Joseph W. Clautice Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)			Myocardial infarction		Sudden
ANTECEDENT CAUSES			(A) IMMEDIATE CAUSE		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			Coronary occlusion		Sudden
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			Arteriosclerotic cardiovascular disease		several years
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 11-26 1960 to 12-6 1972, that (I) (we) last saw the deceased alive on 10-31 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Alfred G. Ossman, Jr. M.D.				12-7-72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Alfred G. Ossman, Jr. M.D.				1101 St. Paul Street	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		12-9-72		New Cathedral Cemetery	
				Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
DEC 7 1972		Sidney H. Heston		H. W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

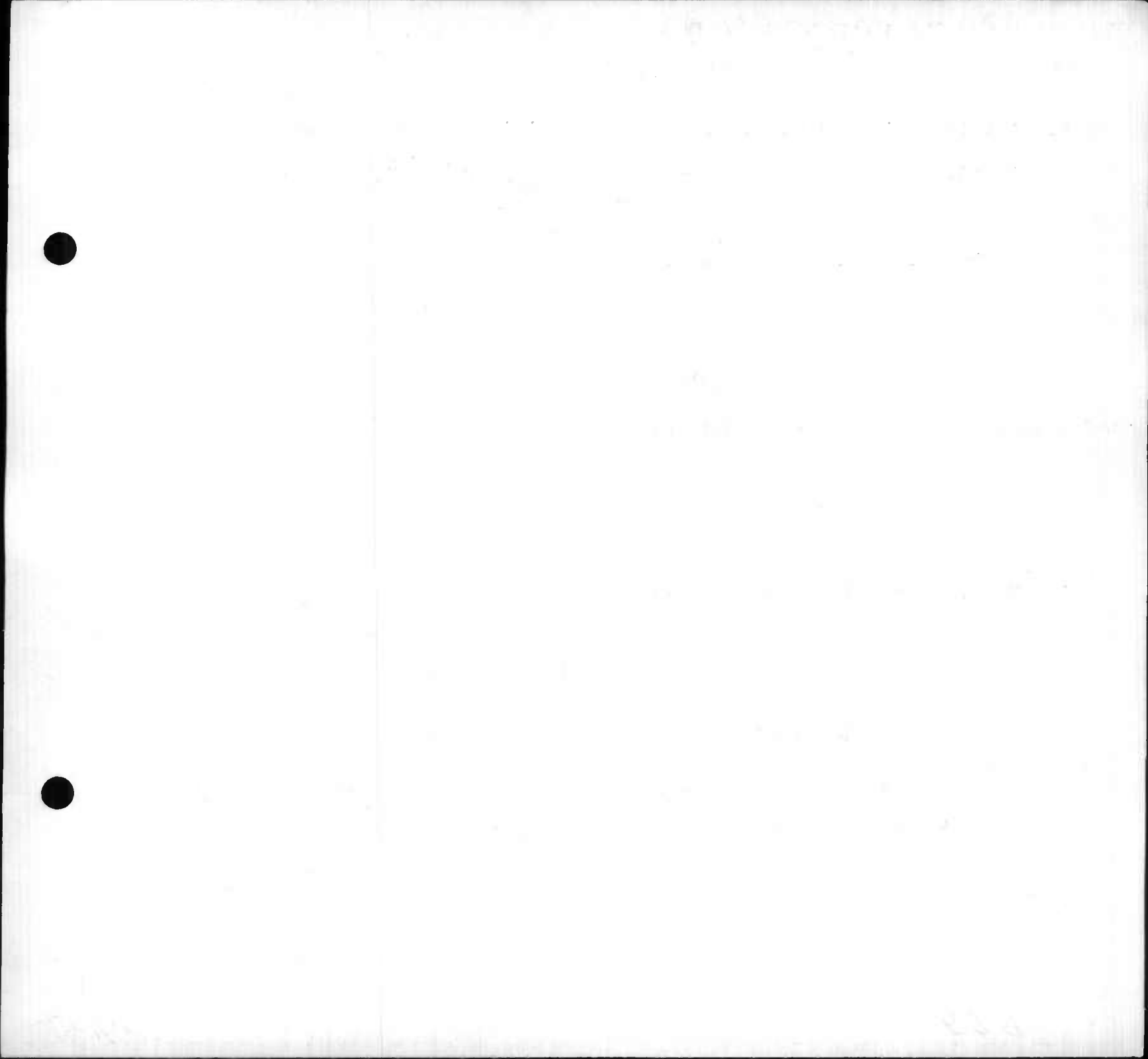
1. NAME OF DECEASED (Type or Print) <b>FRANCIS BURTON</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>604 Collett St.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour M. <b>12 3 1972 8:05p</b>	
6. SEX <b>female</b>		7. RACE <b>negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>1918</b>		10. AGE (In years last birthday) <b>58</b>	
11. BIRTHPLACE (State or foreign country) <b>Florida</b>		12. CITIZEN OF WHAT COUNTRY? <b>A</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME <b>??</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>Mr Robert Mitchell, 1204 Gustayn St</b>		ADDRESS	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Hypertensive cardiovascular disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b> Deputy Chief Medical Examiner CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>12-4-72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/9/72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt Calvary Cemetry</b>		24D. LOCATION (City, town, or county) (State) <b>A A County Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 7 1972</b>		25B. NAME OF REGISTRAR <b>Adolphus Halstead</b>	
25C. FUNERAL DIRECTOR <b>Adolphus Halstead</b>		ADDRESS <b>1206 W North Ave</b>	

WATKINS

13

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 72 11601		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 579	
STATE OF MARYLAND-DHMH		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Clark, Mary</u>		2. DATE AND HOUR OF DEATH <u>12/5/72</u> <u>8 p.</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Baltimore County</u> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Park Hill Nursing Home</u> <u>1802 Eutan Place</u> <u>Baltimore, Maryland 21217</u>		C. CITY OR TOWN <u>202 Estate Rd</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER <u>Reisterstown, Md</u>		5. SEX <u>Female</u> 6. RACE <u>White</u>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-17-97</u>		9. AGE (In years last birthday) <u>75</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME			
14. MOTHER'S MARDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
18. <u>412.3 I</u> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		arteriosclerotic heart disease <u>sev. yrs.</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		chronic brain syndrome <u>several yrs.</u>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>no</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <u>12-1-1972</u> to <u>12-5-72</u> 19 <u>72</u> that (U) (we) last saw the deceased alive on <u>12-5-1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>E Ellsworth Cook</u>		23B. DATE SIGNED <u>12-7-72</u>		23C. PHYSICIAN'S NAME (Type) <u>E ELLSWORTH COOK M.D.</u>	
23D. ADDRESS <u>2431 MARYLAND AVE. BALTO Md. 21218</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>12/8/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>mt auburn</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 7 1972</u>		25B. NAME OF REGISTRAR <u>Sidney W. H. H. H.</u>		25C. FUNERAL DIRECTOR <u>1206 W. H. H. H.</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 11605	
72 11605 CERTIFICATE OF DEATH				STATE OF MARYLAND-DHMH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		HARRY P. STROUP		12-7-72 4 27 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 43 SOUTH BALTIMORE GENERAL HOSPITAL				A. STATE MARYLAND	
				B. COUNTY BALTIMORE CITY 2572	
				C. CITY OR TOWN BALTIMORE	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 2606 W PATAPSCO AVE	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 4-9-04	9. AGE (in years last birthday) 68	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BAKER		10B. KIND OF BUSINESS OR INDUSTRY SMITH BAKERY		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME HENRY STROUP			14. MOTHER'S MAIDEN NAME LAURA LUTON		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO. 232-01-0560		17. INFORMANT HARRY H. Stroup (Son) 4212 Doris Ave., Balto. #25	
18. 410.9 I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: VENTRICULAR ARRHYTHMIA		30 MINS	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) ACUTE MYO CARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF:		12 DAYS	
		(C) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE		2+ YEARS	
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CHRONIC OBSTRUCTIVE AIRWAY DISEASE 15-20 YEARS	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from NOVEMBER 28 19 72 to DECEMBER 7 19 72 that (2) (we) last saw the deceased alive on DECEMBER 7 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (3) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Theodore H. Cryer M.D.				23B. DATE SIGNED 12-07-72	
23C. PHYSICIAN'S NAME (Type) THEODORE H. CRYER M.D.				23D. ADDRESS SOUTH BALTIMORE GENERAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/9/1972		24C. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery	
24D. LOCATION A. Arundel Co.; Glen Burnie, Md. 21061		24E. ADDRESS 237 Patapsco Ave., Balto. 21225			
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1972		25B. NAME OF REGISTRAR Sidney H. ...		25C. FUNERAL DIRECTOR McCully ...	



THE [illegible] OF [illegible]

[illegible text block]

[illegible text block]

[illegible text block]

[illegible text block]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

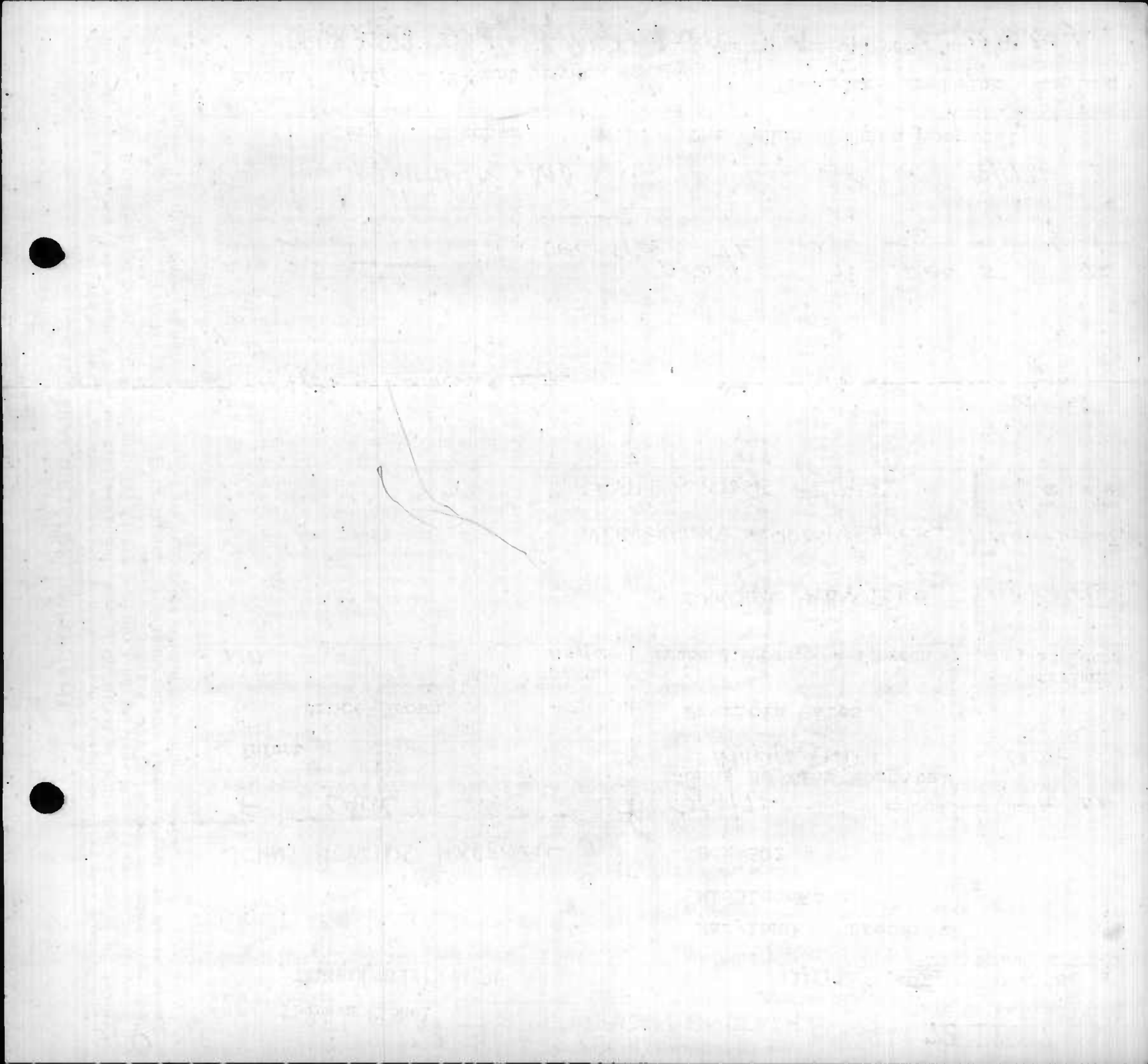
BALTIMORE CITY HEALTH DEPARTMENT				72 11606		72 11606	
CERTIFICATE OF DEATH				STATE OF MARYLAND-DEM			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
		ANNA SPORA		12-5-72		3:10 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 LINCOLN MEM. NURSING 27 N. CAREY ST. Home				A. STATE Crownsville State Hospital			
				C. CITY OR TOWN CROWDSVILLE ARUNDEL		D. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER MARYLAND				5. SEX F			
6. RACE CAY.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-26-88		9. AGE (In years last birthday) 84	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Red Cross worker		10B. KIND OF BUSINESS OR INDUSTRY ?		11. BIRTH PLACE (State or foreign country) Iland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-74-8409		17. INFORMANT HOSPITAL RECORDS		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osihenio, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH I 189.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Tumor of right kidney (B) Abdominal Carcinomatosis DUE TO, OR AS A CONSEQUENCE OF: (C) Anemia			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7-25-1972 to 12-5-1972, that (I) (we) last saw the deceased alive on 12-5-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE A. I. Baykaler, M.D.				23B. DATE SIGNED 12-5-72			
23C. PHYSICIAN'S NAME (Type) A. I. BAYKALER, M.D.				23D. ADDRESS 301 Mc Mechen St. Balto.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-7-72		24C. NAME OF CEMETERY OR CREMATORY St. Stanislaus		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1972		25B. NAME OF REGISTRAR Sidney H. Horkin		25C. FUNERAL DIRECTOR W. FIADKOWSKI		ADDRESS 2007 EASTERN	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

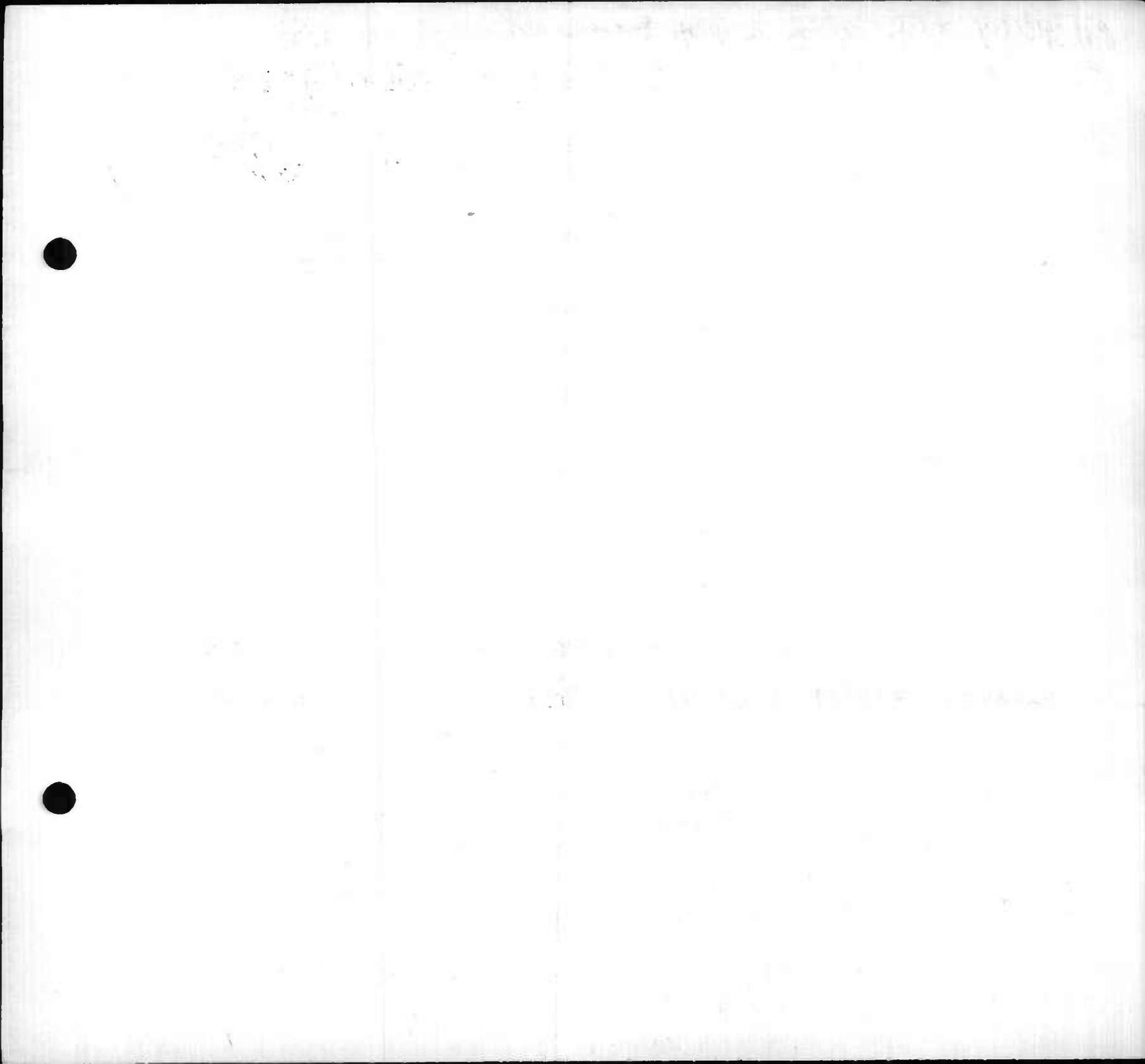
B-6501		6c 72-17906		72 11607		CITY HEALTH DEPARTMENT		X		REG. NO. 72 11607	
BIRTH NO.		Theresa Michel		CERTIFICATE OF DEATH				STATE OF MARYLAND-DEMCH			
1. NAME OF DECEASED (Type or Print)		Baby <del>xxxx</del> Brown		2. DATE AND HOUR OF DEATH		12/5/72		5:40 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE		B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Maryland		Frederick		6000	
JOHNS HOPKINS HOSPITAL						C. CITY OR TOWN		D. INSIDE CITY LIMITS?			
						Middleton		YES <input checked="" type="checkbox"/>		NO <input type="checkbox"/>	
E. STREET AND NUMBER						Box 302					
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.	
F	CAUC	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		12/4/72						16 22	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
Infant				Johns Hopkins Hospital MARYLAND		USA					
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME							
Bruce Brown				Patricia Gates							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
NO		NONE		Bruce M. Brown, 68 Jefferson Village,		Maryland					
18. 774.91		CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		CARDIAC ARRYSTOLE		immediate					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(B) IRREVERSIBLE ANOSIS/SHOCK		16 hrs + intratun							
ANTECEDENT CAUSES		(C) ERYTHROBLASTOSIS FETALIS		16 hrs + intra		uterine					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.											
II											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
12/4/72		ERYTHROBLASTOSIS		Yes		NO					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?							
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>									
22. I certify that (I) (this hospital) attended the deceased from		DEC. 4		19 72 to		DEC. 5		19 72			
that (I) (we) last saw the deceased alive on		DEC. 5, 19 72		and that in (my) (our) opinion death occurred on the date							
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE		23B. DATE SIGNED									
Gary R. Gutter, M.D.		12/5/72									
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS									
Gary R. Gutter, M.D.		The Johns Hopkins Hospital									
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)					
Burial		12/8/1972		Mount Olivet Cemetery		Frederick Frederick Maryland					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		25D. ADDRESS					
DEC 8 1972		Sidney J. Keeney		106 East Church St.		Frederick, Md.					
						FOREN HOME					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 11608		72 11608	
BIRTH NO.		REG. NO.		STATE OF MARYLAND-DEATH	
1. NAME OF DECEASED (Type or Print) <b>SCHROTH, BABY GIRL</b>		2. DATE AND HOUR OF DEATH <b>DECEMBER 5, 1972 3:00P M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>University of Maryland Hospital</b> <b>Greene Street, Baltimore, Md 21201</b>		A. STATE <b>MD</b> 21403 B. COUNTY <b>AA</b> 5210			
C. CITY OR TOWN <b>ANNAPOLIS</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER <b>22 East Bens drive</b>					
5. SEX <b>F</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/4/72</b>	9. AGE (In years last birthday)	If Under 1 Yr. Months Days Hours Min. <b>1</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MD</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Donald Lee</b>		14. MOTHER'S MAIDEN NAME <b>PATRICIA DIANE Schroth</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>AZAD CADER, University Hospital, Md.</b>	
18. <b>772.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>CEREBRAL HEMMORHAGE</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>PREMATURITY</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CEREBRAL HEMMORHAGE</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>PREMATURITY</b> (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 hours</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12/4/1972</b> to <b>12/5/1972</b> that (I) (we) last saw the deceased alive on <b>12/5/1972</b> and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Azad Cadar MD</b>		23B. DATE SIGNED <b>12/5/72</b>		23C. PHYSICIAN'S NAME (Type) <b>AZAD CADER MD</b>	
23D. ADDRESS <b>University Hospital, Balto, Md.</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>12-7-72</b>	24C. NAME of CEMETERY or CREMATORY <b>Hillcrest Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>ANNAPOLIS SAC MD</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 8 1972</b>	25B. NAME OF REGISTRAR <b>Sidney R. ...</b>	25C. FUNERAL DIRECTOR <b>Hardisty Funeral Home, Annapolis Md</b>			





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 11609

BIRTH NO.

STATE OF MARYLAND-DEPT

1. NAME OF DECEASED (Type or Print) CHARLES E. DRONEBURG		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 277 Druid Hill Park Lake Drive		3. DATE PRONOUNCED DEAD Month Day Year Hour December 4, 1972 5:45 P. M.	
6. SEX Male	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore
9. DATE OF BIRTH Aug. 11, 1898	10. AGE (In years last birthday) 74	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U. S. A.
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 214-10-2566	
18. INFORMANT Davis Breeding, 931 Impala Court, Baltimore, Md. 21221		19. CAUSE OF DEATH Arteriosclerotic cardiovascular disease	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C)	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/5/72	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE Dec. 6, 1972	24C. NAME of CEMETERY or CREMATORY Mount Olivet Cemetery	24D. LOCATION (City, town, or county) (State) Frederick, Maryland
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1972	25B. NAME OF REGISTRAR Sidney Indeston	25C. FUNERAL DIRECTOR Smith, Fadelley, Keeney, Basford Funeral Home 106 East Church St., Frederick, Md. 21701	

*[Faint, illegible text, likely bleed-through from the reverse side of the page]*

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## 72 11610 CERTIFICATE OF DEATH

REG. NO.

72 11610

STATE OF MARYLAND-DHMH

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

ANNIE M. SAMUEL

2. DATE AND HOUR OF DEATH

12/6/72

3:00 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

SOUTH BALTIMORE GENERAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Maryland - Baltimore

2534

C. CITY OR TOWN

Baltimore, Md.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

220 Washburn Avenue

5. SEX

F

6. RACE

W

7. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

5-2-95

9. AGE (in years last birthday)

77

10. Under 1 Yr.

Months: Days: Hours: Min.

If Under 24 Hrs.

Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Dec.

14. MOTHER'S MAIDEN NAME

Dec.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

220 22 4217

17. INFORMANT

Clara Bradburn 220 Washburn Ave 21225

ADDRESS

18.

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

PNEUMONIA

4 DAYS

(B)

DUE TO, OR AS A CONSEQUENCE OF:

CHRONIC OBSTRUCTIVE AIRWAY DISEASE. SEVERAL YRS.

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/3 19 72 to 12/6 19 72 that (I) (we) last saw the deceased alive on 12/6 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Robert J. Bauer, M.D.

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

12/6/72

23C. PHYSICIAN'S NAME (Type)

ROBERT J. BAUER, M.D.

23D. ADDRESS

3001 S. HANOVER ST. BALTIMORE, MD.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Dec. 9/72

24C. NAME OF CEMETERY OR CREMATORY

Meadowridge Cemetery

24D. LOCATION

Donsey Md.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

DEC 8 1972

25B. NAME OF REGISTRAR

Sidney [Signature]

25C. FUNERAL DIRECTOR

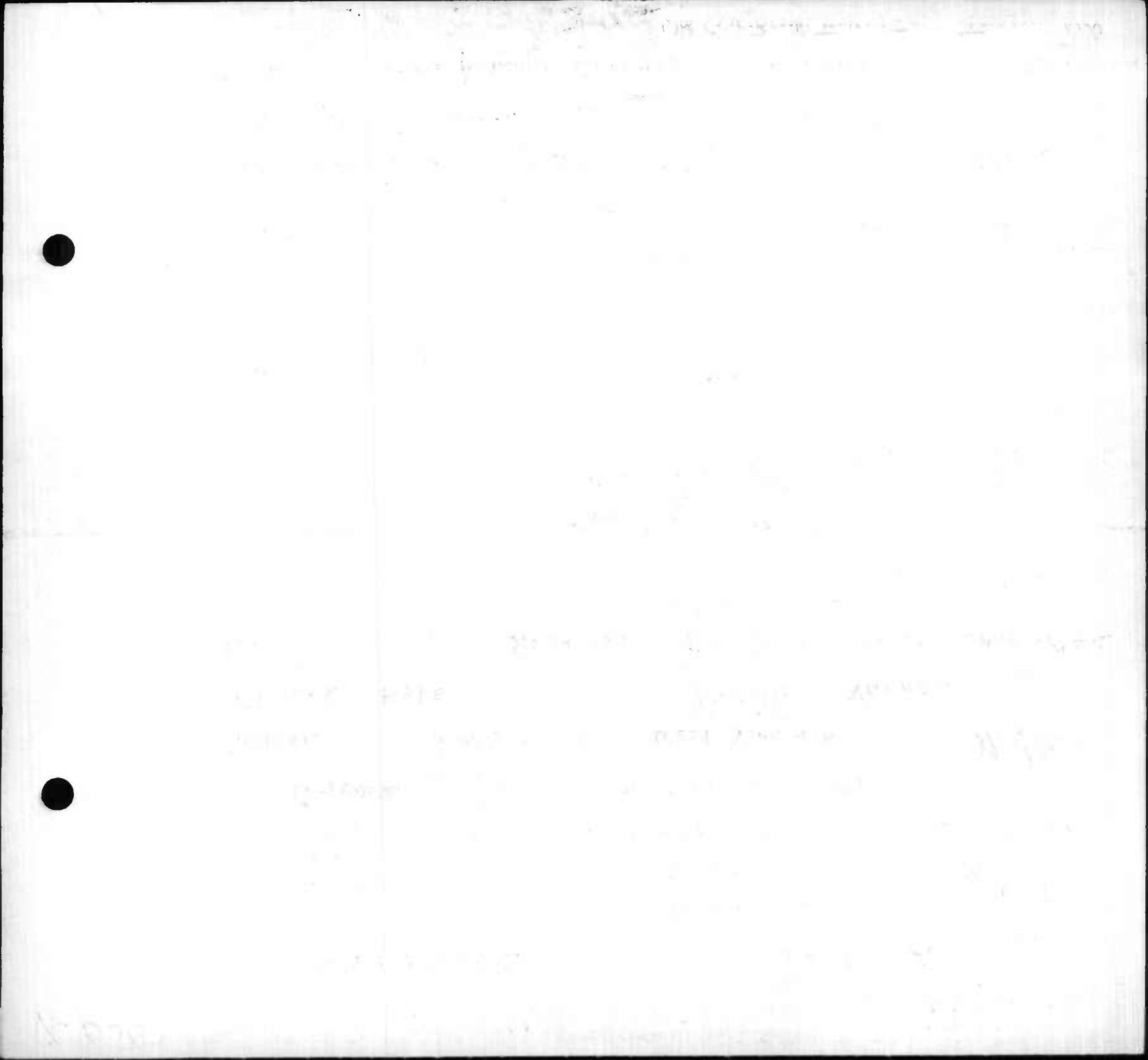
Molly [Signature] 237 [Signature] Ave Alto 21225

ADDRESS



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 11611	
72 11611				STATE OF MARYLAND-DEMH	
BIRTH NO.				12-6-72	
1. NAME OF DECEASED (Type or Print) <b>NANCY VARNER</b>				2. DATE AND HOUR OF DEATH	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>35 CHURCH HOME + HOSP. 100 N. BROADWAY BALTIMORE, MARYLAND 21231</b>				A. STATE <b>MARYLAND</b> B. COUNTY <b>105</b>	
C. CITY OR TOWN <b>BALTIMORE</b>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>404 S. COLLINGTON AVE 21231</b>					
5. SEX <b>F</b>	6. RACE <b>CAUCASIAN</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>9/18/36</b>	9. AGE (In years last birthday) <b>36</b>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CASHIER</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>DEPT. STORE</b>		11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>			13. FATHER'S NAME <b>Edward Kyle</b>		
14. MOTHER'S MAIDEN NAME <b>Lucille VARNER</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>212-34-8311</b>			17. INFORMANT <b>Lucille Varnier</b> ADDRESS <b>SAME AS 4R</b>		
18. <b>45101</b> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Massive pulmonary embolus</b>					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
(B) <b>Possible M.I.</b> DUE TO, OR AS A CONSEQUENCE OF:					
(C) <b>Phlebitis @ leg</b>					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from <b>October 1972</b> to <b>12/6 1972</b> that (I) (we) last saw the deceased alive on <b>12/1 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>I. R. Anderson MD</b>				23B. DATE SIGNED <b>12/6/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Ian R Anderson MD</b>				23D. ADDRESS <b>2E. Read St Baltimore</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12-10-1972</b>		24C. NAME OF CEMETERY OR CREMATORY <b>ARBORALE CEMETERY</b>	
24D. LOCATION <b>ARBORALE</b>		24E. CITY, TOWN, OR COUNTY (State) <b>WEST VIRGINIA</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 8 1972</b>		25B. NAME OF REGISTRAR <b>Sidney H. Heston</b>		25C. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Townsend Inc.</b> ADDRESS <b>TOWSON, MD.</b>	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 11612</b>
72 11612				STATE OF MARYLAND-DMH
BIRTH NO.		2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>HARRISON, ELsie E.</b>		12/5/1972 4:05 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> 8. COUNTY <b>1348</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Union Memorial Hospital</b> <b>44</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <b>3860 FALLS ROAD</b>				
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-11-1898</b>	9. AGE (In years last birthday) <b>73</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>UNEMPLOYED</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>TEXTILE MILL</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
13. FATHER'S NAME <b>SAMUEL BIGHAM</b>		14. MOTHER'S MAIDEN NAME <b>ELLA YINGLING</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216-16-6283</b>		17. INFORMANT <b>LOLA RAY (DAUGHTER)</b>
18. <b>269.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Ch. T. I ; PULMONARY Fibrosis</b>		CAUSE OF DEATH <b>Ch. T. I ; PULMONARY Fibrosis</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPST? (Yes or No)
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>12-03</b> 19 <b>12</b> to <b>12-05</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>12-05</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Lucy Sirotycky M.D.</b>				23B. DATE SIGNED <b>12/5/72</b>
23C. PHYSICIAN'S NAME (Type) <b>LUIS SIROTYCKY M.D.</b>		23D. ADDRESS <b>U. M. H.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12/8/72</b>	24C. NAME OF CEMETERY OR CREMATORY <b>WOODLAWN</b>	24D. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 8 1972</b>		25B. NAME OF REGISTRAR <b>Sidney [Signature]</b>		25C. FUNERAL DIRECTOR <b>Paul [Signature]</b>
				ADDRESS <b>3617 Chestnut Ave.</b>



1915-1916

1917-1918

1919-1920

1921-1922

1923-1924

1925-1926

1927-1928

1929-1930

1931-1932

1933-1934

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 11613	
72 11613				STATE OF MARYLAND-DEMR	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>EARL S. Robinson</u>		2. DATE AND HOUR OF DEATH <u>12/4/72</u> <u>6<sup>50</sup> P. M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>BALTIMORE</u>		5. CITY OR TOWN <u>Glen Arm</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Edgewood Nursing Home</u> 12-20-72		E. STREET AND NUMBER <u>11817 Manor Rd.</u>			
6. RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-13-1904</u> 9. AGE (In years last birthday) <u>68</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Commercial Artist</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Artist</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>James Dwight Robinson</u>		14. MOTHER'S MAIDEN NAME <u>Nettie M. Kinnamon</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-32-8087</u>		17. INFORMANT <u>Mrs. Mildred A. Robinson</u> ADDRESS <u>21057 Manor Rd.</u>	
18. <u>412.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. If means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Hypertensive Cardio-Vascular Dis.</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Mitral &amp; Tri-cuspid insufficiency</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Coronary Artery Dis.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>11/20/72</u> to <u>12/4/72</u> , that (I) (we) last saw the deceased alive on <u>12/4/72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Anthony F. Carozza</u>		23B. DATE SIGNED <u>12/5/72</u>		23C. PHYSICIAN'S NAME (Type) <u>ANTHONY F. CAROZZA</u>	
23D. ADDRESS <u>5217 YORK RD Balto Md 21212</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/7/72</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		24D. LOCATION (City, town, or county) <u>Parkville Baltimore Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 8 1972</u>	
25B. NAME OF REGISTRAR <u>Sidney H. ...</u>		25C. FUNERAL DIRECTOR <u>Classen Funeral Home</u>		ADDRESS <u>7401 Belair Rd. Balto.</u>	

12-20-1972 - Correction letter from the Lassahn Funeral Home, 7401 Belair Road, Balto., Md. 21236

HS

RECEIVED  
FBI BALTIMORE  
DEC 21 1972  
6-13-1972

Handwritten notes, possibly a signature or address, appearing upside down.

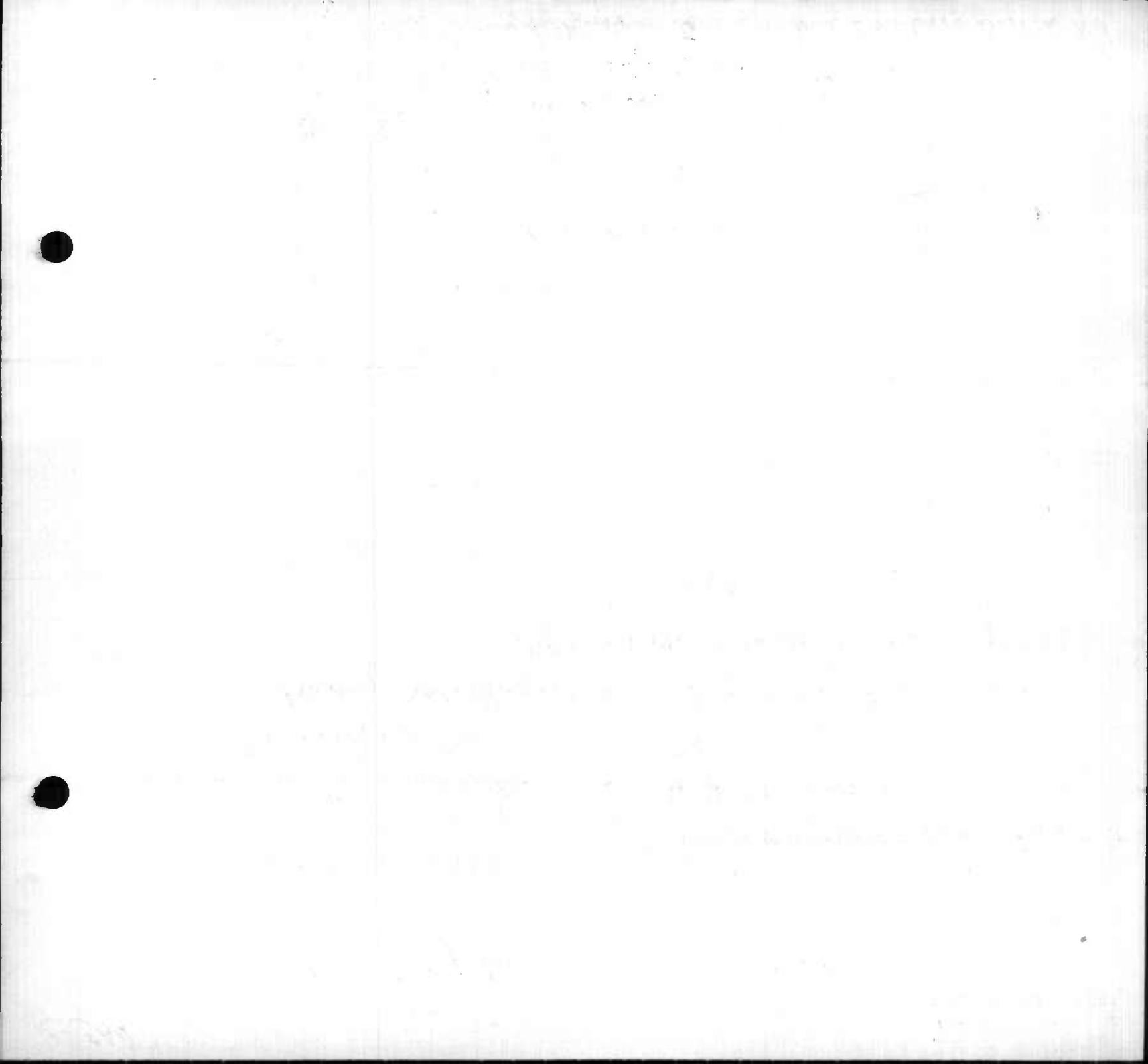
11/21/72

Handwritten signature or initials.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 72 11614 CERTIFICATE OF DEATH				REG. NO. 72 11614 STATE OF MARYLAND-DHMH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Rudd - Ruby H.</u>		2. DATE AND HOUR OF DEATH <u>12-6-72</u> <u>1</u> <u>630</u> P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE _____ B. COUNTY _____		
FULL NAME OF HOSPITAL OR INSTITUTION <u>CHURCH HOME &amp; HOSPITAL</u>			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <u>120 N Broadway 1743 Fleet St.</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-13-09</u>	9. AGE (In years last birthday) <u>63</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>VA</u>	
13. FATHER'S NAME <u>Harry W. Harrison</u>			14. MOTHER'S MAIDEN NAME <u>Elizabeth Blakenship</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>911-49-691</u>		17. INFORMANT <u>MRS. MEANIE WOOLDRIDGE-1032 Byswick Lane</u>	
18. <u>436.9</u> I CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <u>CVA.</u> DUE TO, OR AS A CONSEQUENCE OF:  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12-4-1972</u> to <u>12-6-1972</u> that (I) (we) last saw the deceased alive on <u>6:50 P.M. 12-6-1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Reza-Sajadi</u> M.D. DEGREE				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>REZA-SAJADI</u>				23D. ADDRESS <u>CHURCH HOME &amp; HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-4-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>RIVERVIEW Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Richmond, Va.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 8 1972</u>		25B. NAME OF REGISTRAR <u>Sidney H. Hester</u>		25C. FUNERAL DIRECTOR <u>JOHN C. MINER INC.-6415 Belair Rd.</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
72 11615 CERTIFICATE OF DEATH						REG. NO. 72 11615					
BIRTH NO.						2. DATE AND HOUR OF DEATH					
1. NAME OF DECEASED (Type or Print)						3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					
ATHERTON, VADNIA ELLEN						DECEMBER 6, 1972 1:20A M.					
FULL NAME OF HOSPITAL OR INSTITUTION						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)						A. STATE B. COUNTY					
40 ST. AGNES HOSPITAL						MARYLAND BALTIMORE 21207					
5. SEX						6. DATE OF BIRTH					
FEMALE						10 26 88					
7. RACE						9. AGE (In years last birthday)					
CAUCASIAN						84					
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>						10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>						Packer					
11. BIRTHPLACE (State or foreign country)						12. CITIZEN OF WHAT COUNTRY?					
WEST VIRGINIA						U.S.A.					
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
SANFORD BAXTER						MARTHA (STATON)					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service						16. SOCIAL SECURITY NO.					
NO						214207993					
17. INFORMANT						18. CAUSE OF DEATH					
RECORDS OF ST. AGNES HOSPITAL						DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
CATON & WILKENS AVES. BALTO., MD. 21229						(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)					
						(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
						CEREBRAL INFARCT (Basal Ganglia) 2 WKS.					
						(B) DUE TO, OR AS A CONSEQUENCE OF:					
						(C) _____					
						II					
						OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
						BRONCHOPNEUMONIA 12 HRS.					
19A. DATE OF OPERATION						19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					
2											
20A. AUTOPSY? (Yes or No)						20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
YES						YES					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)						21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)											
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)						21E. INJURY OCCURRED					
						While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
21F. HOW DID INJURY OCCUR?											
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from NOVEMBER 24 19 72 to DECEMBER 6 19 72, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on DECEMBER 6 19 72 and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (XXX) view the body after death.											
23A. SIGNATURE						23B. DATE SIGNED					
Robert W. Ashmore, M.D.						12-6-72					
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS					
R ASHMORE, M.D.						CATON & WILKENS AVES. BALTO., MD. 21229					
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE		24C. NAME OF CEMETERY OR CREMATORY				24D. LOCATION (City, town, or county) (State)	
burial				12/9/72		Lorraine Park (Mausoleum)				Balto/Md.	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR				25C. FUNERAL DIRECTOR			
DEC 8 1972				Audrey J. [Signature]				John T. Barsbury 6411 Windsor Mill Rd.			

U.S. AIR FORCE

OFFICE OF THE SECRETARY OF THE AIR FORCE

X XXX

DECEMBER 2

15

NOVEMBER 30

15

DECEMBER 2

15

NO

STANDARD

OFFICE OF THE SECRETARY OF THE AIR FORCE

STANDARD

OFFICE OF THE SECRETARY OF THE AIR FORCE

STANDARD

STANDARD

X

15

15

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-255-1

72 11616

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 72 11616

STATE OF MARYLAND-DHME

BIRTH NO.

1. NAME OF DECEASED *W. themina*

(Type or Print)

(MINNIE) WASSMAN

2. DATE AND HOUR OF DEATH

12-3-72

10:00 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

UNIVERSITY HOUSE

501 W. Franklin St.

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN BALTIMORE

E. STREET AND NUMBER

731 N. KENWOOD AVE.

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

5. SEX

F

6. RACE

W

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒

DIVORCED ☐

8. DATE OF BIRTH

10--10-83

9. AGE (In years last birthday)

79 89

11 Under 1 Yr. Months: Days

11 Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Home Maker

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

JOHN BERKOWSKI

14. MOTHER'S MAIDEN NAME

Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

218-90-8650A

17. INFORMANT

ADDRESS

ADMISSION RECORD

18. *4124 I*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE *ASCVD & Cerebrovascular*

DUE TO, OR AS A CONSEQUENCE OF:

*Insufficiency*

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

*Years*

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

*Severe Stasis Dermatitis of Legs*

*Years*

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (H) (this hospital) attended the deceased from *October 19* 19 *72* to *December 3* 19 *72* that (H) (we) last saw the deceased alive on *December 3* 19 *72* and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.

23A. SIGNATURE

*Peter H. Rheinstein, M.D.*

DEGREE

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

*3 December 1972*

23C. PHYSICIAN'S NAME (Type)

PETER H. RHEINSTEIN MD

DEGREE

23D. ADDRESS

UNIVERSITY HOUSE

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

12-6-72

24C. NAME OF CEMETERY OR CREMATORY

St. Michael's Luth. Cem.

24D. LOCATION

(City, town, or county)

Perry Hall, Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

DEC 8 1972

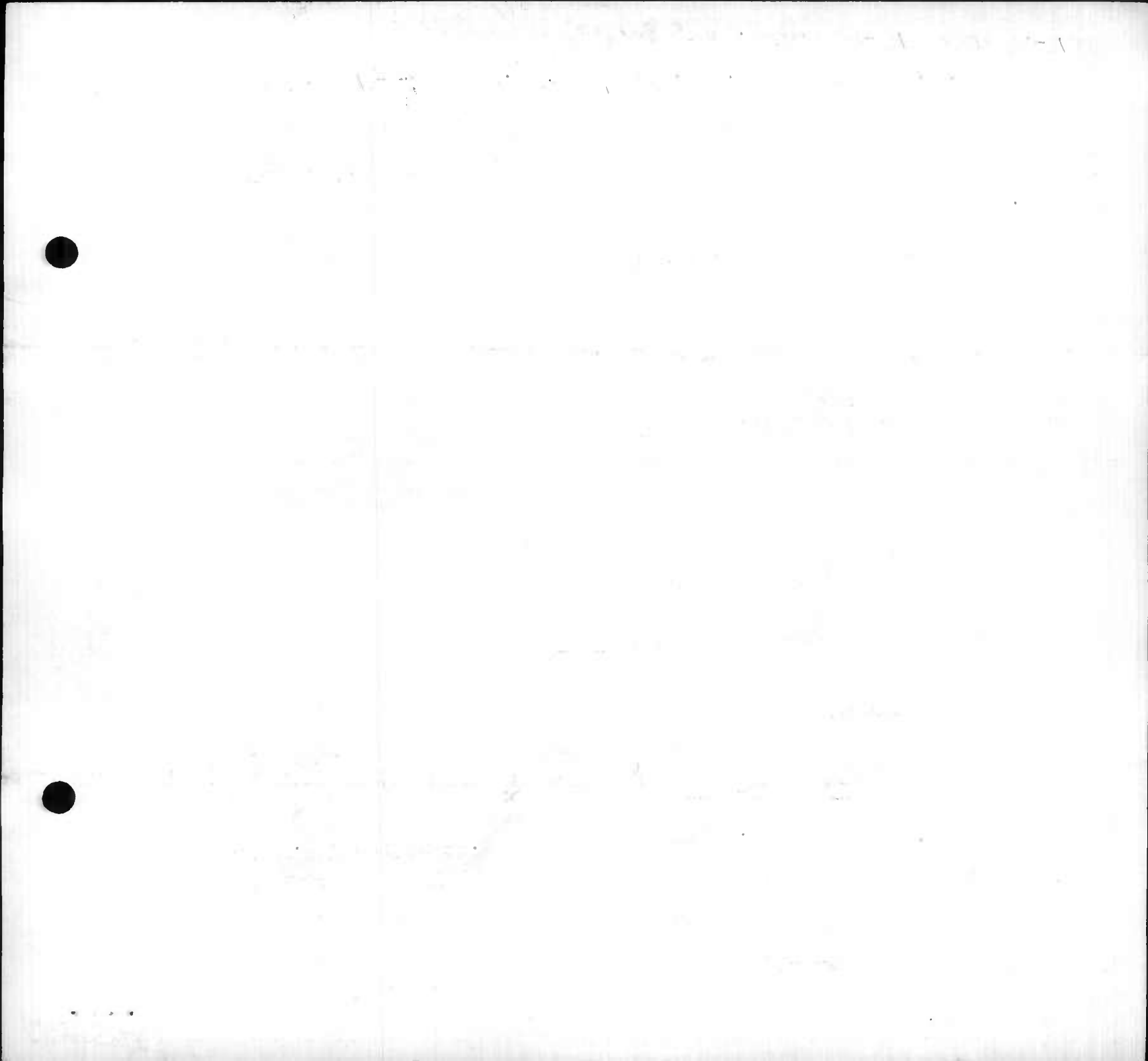
25B. NAME OF REGISTRAR

*Andrew J. Houston*

25C. FUNERAL DIRECTOR

*John C. Migler Inc-6415 Belair Rd.-21206*

ADDRESS



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 11617 BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

REG. NO. 72 11617  
 STATE OF MARYLAND-DEMH

BIRTH NO.

1. NAME OF DECEASED  
 (Type or Print)

*Ana Schneider*

2. DATE AND HOUR OF DEATH

*12-5-72 4:30 PM*

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION

*Lake St Nursing Home  
 2401 Eutaw place*

4. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)  
 A. STATE B. COUNTY

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

*Baltimore  
 2401 Eutaw place*

5. SEX

*F*

6. RACE

*W*

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒

DIVORCED ☐

8. DATE OF BIRTH

*July 23 1877*

9. AGE (In years)

*85*

10. Under 1 Yr.

Months Days

11. Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Home Maker*

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

*Balto. Md.*

12. CITIZEN OF WHAT COUNTRY?

*U.S.A.*

13. FATHER'S NAME

*Adam Winter*

14. MOTHER'S MAIDEN NAME

*Ana Winter (deceased)*

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

*219-54-342*

17. INFORMANT

ADDRESS

*J. F. Fields 2, 4822 Lanier Ave*

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

*Arteriosclerotic cardiovascular disease*

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

*CBS due to Arteriosclerotic cardiovascular disease*

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

*Convulsive disorder*

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

*year*

*year*

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

1 Month 1 Day 1 Year 1 Hour

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from *3-30* 19*72* to *12-5* 19*72* that (I) (we) lost saw the deceased alive on *12-2* 19*72* and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

*W. Adams*

DEGREE

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

*12-5-72*

23C. PHYSICIAN'S NAME (Type)

*W. Adams F. ALBUQUERQUE*

DEGREE

23D. ADDRESS

*395 F. Woodwood Rd  
 PASKOENT Md 21122*

24A. BURIAL CREMATION, REMOVAL (Specify)

*Burial*

24B. DATE

*12-7-72*

24C. NAME OF CEMETERY or CREMATORY

*Holy Redeemer Cemetery*

24D. LOCATION

*Baltimore, Md.*

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

*DEC 8 1972*

25B. NAME OF REGISTRAR

*Sidney H. H. H.*

25C. FUNERAL DIRECTOR

*John C. Miller Inc-6415 Belair Rd.-21206*

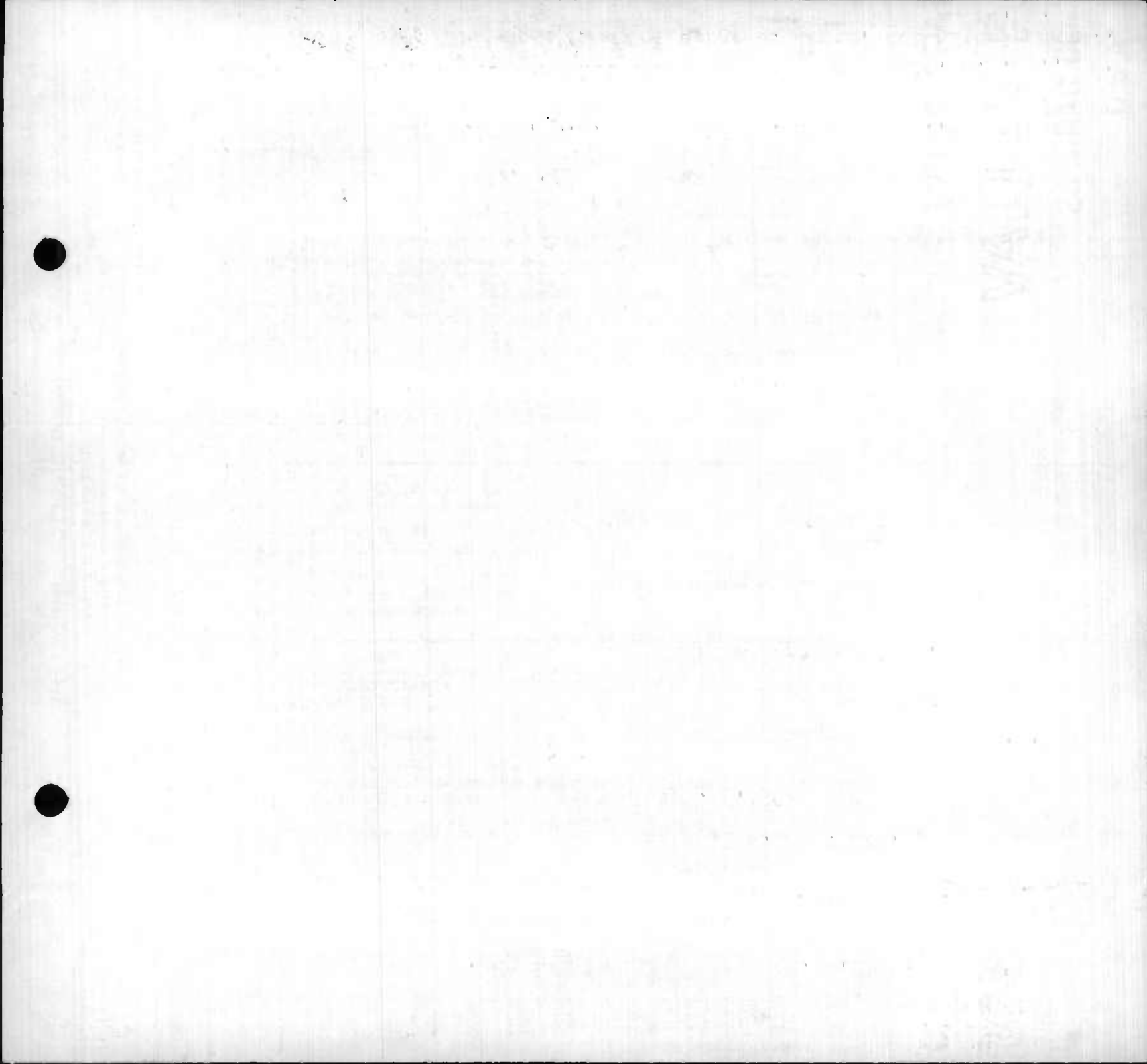
ADDRESS

3/30/72 - Adm.  
PREV ADDRESS 7150 Industrial (Spring Grove)  
DL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 11618	
72 11618 CERTIFICATE OF DEATH				STATE OF MARYLAND - DEWE	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		CLARA A. JANSSENS		Dec. 4, 1972 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 43 South Baltimore General			A. STATE Maryland		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			B. COUNTY		
			C. CITY OR TOWN Baltimore		
			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER 15 W. Fort Ave.		
5. SEX F	6. RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 5, 1902	9. AGE (In years last birthday) 70	If Under 1 Yr. Months: Oays: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Charles Eyerly		14. MOTHER'S MAIDEN NAME Mary Conway		12. CITIZEN OF WHAT COUNTRY? U.S.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Charles Janssens 15 W. Fort Avenue	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Coronary Occlusion 1 hour DUE TO, OR AS A CONSEQUENCE OF: (B) Anteroselective Heart Disease 3-4 years DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Aug 19 <sup>th</sup> 1965 to 12/4 1972. that (I) (we) last saw the deceased alive on 6/28 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Harry Deibel M.D.				23B. DATE SIGNED 12/5/72	
23C. PHYSICIAN'S NAME (Type) Harry Deibel, M.D.				23D. ADDRESS 1226 S. Hanover St., Baltimore	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/9/72		24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cemetery	
24D. LOCATION Glen Burnie, A.A. Co. Md.		24E. DATE REC'D BY HEALTH DEPT. DEC 8 1972		24F. NAME OF REGISTRAR George J. Conce	
24G. DATE REC'D BY HEALTH DEPT.		24H. NAME OF REGISTRAR		24I. FUNERAL DIRECTOR George J. Conce, 4001 Ritchie Hwy., Baltimore, Md.	

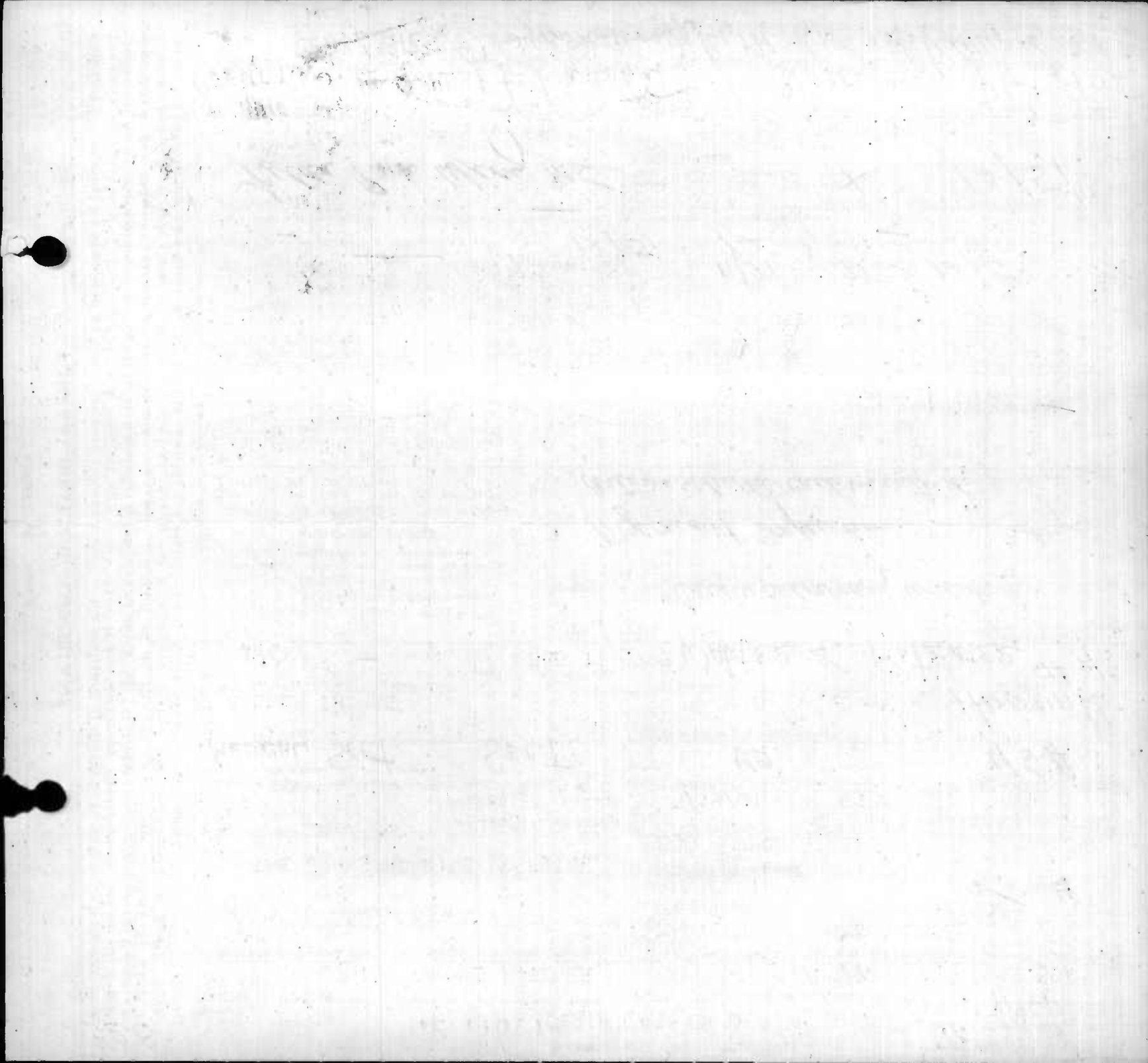


**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 11619	
72 11619				STATE OF MARYLAND-DHME	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		LOUISE THOMAS FITZNER		12/05/72 12.30A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
33 THE JOHNS HOPKINS HOSPITAL			MARYLAND ANNE ARUNDEL 5210		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			ANNAPOLIS		YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>
			E. STREET AND NUMBER		
			830 MONROE STREET		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
F	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9/18/01	71	MEDICAL SECT.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		SECT.		VA.	USA
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
WALKER THOMAS			RUTH CALLOWAY HUDNALL		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
NO			888 11 5797		WALTER K. FITZNER #4
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
410.91					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			Cardio pulmonary arrest		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) Procedural Defection 3 days		
			(C) Anticoagulant Cardiovascular Disease		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 11/21 19 72 to 12/5 19 72, that (I) (we) lost saw the deceased alive on 12/5 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Nelda Park Wray M.D.				12/5/	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
NELDA PARK WRAY, MD				THE JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
CREMATION		12-8-72		Ft. Lincoln	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
DEC 8 1972		Andrew J. [unclear]		Bladensburg P.G. MD. 77th & [unclear] Annapolis, Md.	





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-3521

72 11620

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

72 11620

STATE OF MARYLAND-DHMH

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Loudenslager Genevieve

2. DATE AND HOUR OF DEATH

12/5/72

12 45 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

90

Melchor Nursing Home  
24th & Charles Sts.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Md.

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

3920 Beech Ave.

5. SEX

F

6. RACE

W

7. MARRIED ☐

NEVER MARRIED ☐

WIDOWED ☒

DIVORCED ☐

8. DATE OF BIRTH

1-29-83

9. AGE (in years last birthday)

89

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

housewife.

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

md.

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Lewis Lucy

14. MOTHER'S MAIDEN NAME

Dunn.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

217-24-9562 F2

17. INFORMANT

son:

ADDRESS

62 F2 Russell Loudenslager 3920 Beech Ave.

18. 4/24 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

Arteriosclerotic Cardiovascular Disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Several years

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from April 30 19 69 to Dec 5 19 72 that (I) (we) last saw the deceased alive on Dec 4 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Loy M. Zimmerman M.D.

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

12/5/72

23C. PHYSICIAN'S NAME (Type)

Loy M. Zimmerman M.D.

23D. ADDRESS

3202 Harford Rd, Baltimore, Md. 21214

24A. BURIAL CREMATION REMOVAL (Specify)

Burial

24B. DATE

12/8/72

24C. NAME OF CEMETERY OR CREMATORY

St. Marys Cem (Hampden)

24D. LOCATION

(City, town, or county) (State)

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

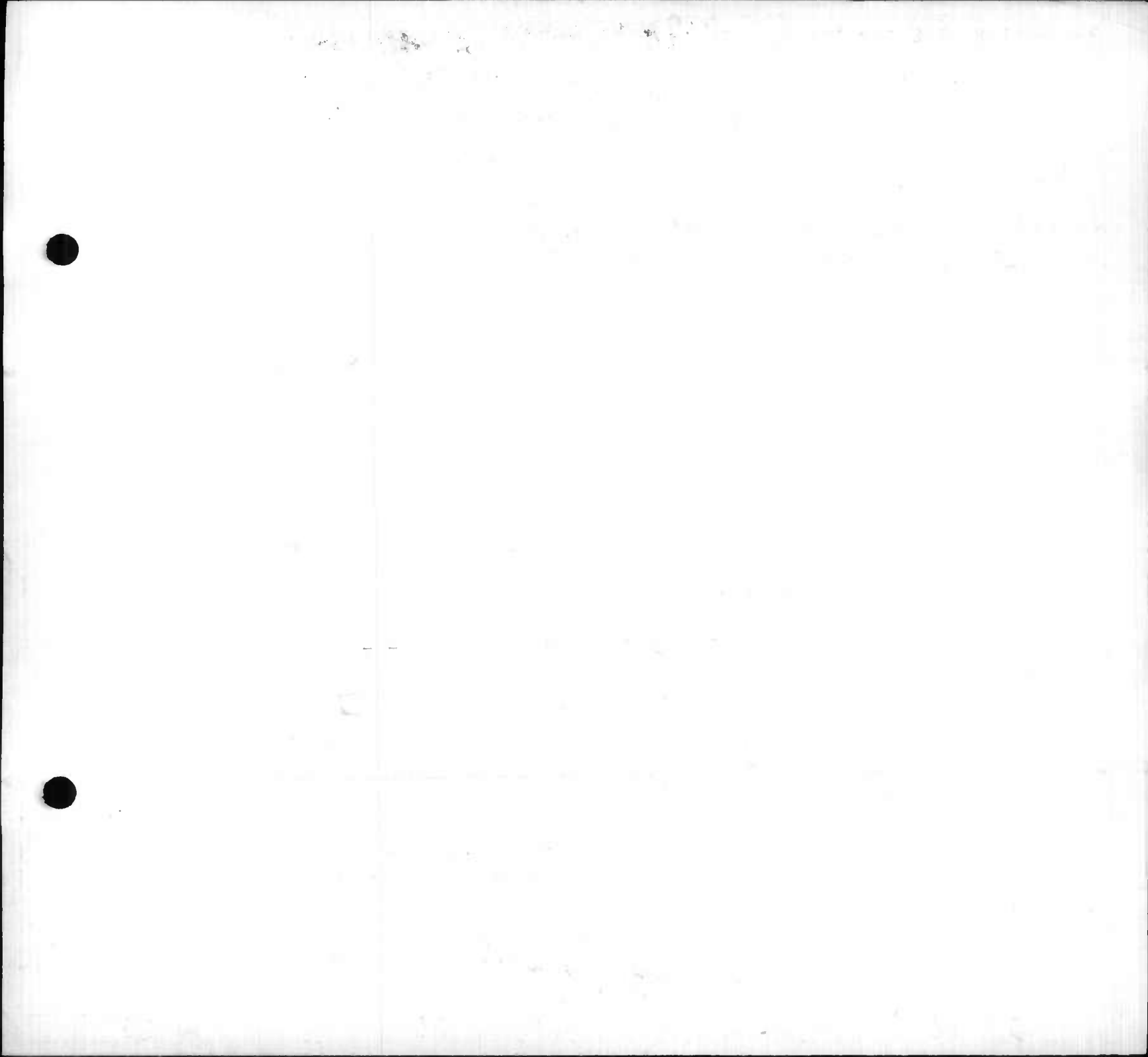
DEC 8 1972

25B. NAME OF REGISTRAR

A. Alap

25C. FUNERAL DIRECTOR

A. Alap gitz, Jr. 3818 Roland Ave



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 11621

BIRTH NO.

STATE OF MARYLAND-DEMH

1. NAME OF DECEASED (Type or Print) William W. Bates		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 12 Day 6 Year 72 Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3825 Roland Avenue 21211		3. DATE PRONOUNCED DEAD Month 12 Day 6 Year 72 Hour 8:17 a. M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1307			
6. SEX male	7. RACE White	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH DEC 11, 1898		10. AGE (In years lost birthday) 73	
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Bates		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	
15. MOTHER'S MAIDEN NAME Unknown		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 212-05-5622		18. INFORMANT ADDRESS A Cecilia Bates 3825 Roland Ave. 21211	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Chronic obstructive pulmonary disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic, M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/6/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/9/72	
24C. NAME of CEMETERY or CREMATORY Meadowridge Memorial Pk		24D. LOCATION (City, town, or county) (State) Howard Co., Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1972		25B. NAME OF REGISTRAR Sidney [Signature]	
25C. FUNERAL DIRECTOR A. Alan Seitz, Jr.		25D. ADDRESS 3818 Roland Ave.	

10/10/1918

10/10/1918

10/10/1918

10/10/1918

10/10/1918

10/10/1918

10/10/1918

10/10/1918

10/10/1918

10/10/1918

10/10/1918

10/10/1918

10/10/1918

10/10/1918

10/10/1918

10/10/1918

10/10/1918

10/10/1918

10/10/1918

10/10/1918

10/10/1918

10/10/1918

10/10/1918

10/10/1918

10/10/1918

10/10/1918

10/10/1918

10/10/1918

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 11622 BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 72 11622

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) **SMITH, CHARLES WALTER**

2. DATE AND HOUR OF DEATH **12-6-72** **11:30 A.M.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) **Veterans Administration Hospital**  
**3900 Loch Raven Blvd.,**  
**Baltimore, Md. 21218**

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE **MARYLAND**  
B. COUNTY **902**

C. CITY OR TOWN **BALTIMORE**

D. INSIDE CITY LIMITS? YES ☒ NO ☐

E. STREET AND NUMBER **1531 Argonne Drive**

5. SEX **MALE**

6. RACE **WHITE**

7. MARRIED ☒ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH **3-5-13**

9. AGE (In years last birthday) **59**

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **DOORMAN RET.**

10B. KIND OF BUSINESS OR INDUSTRY **Guilford Towers**

11. BIRTHPLACE (State or foreign country) **BALTIMORE, MARYLAND**

12. CITIZEN OF WHAT COUNTRY? **U. S. A.**

13. FATHER'S NAME **Charles Walter Smith, Sr.**

14. MOTHER'S MAIDEN NAME **Annie Hofer**

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service) **YES 4-16-42 to 11-1-43**

16. SOCIAL SECURITY NO. **213 13 11 96**

17. INFORMANT **Medical Records**  
**VA Hospital, Baltimore, Md. 21218**

ADDRESS \_\_\_\_\_

18. **162.1 I** CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE **CARCINOMA OF LUNG**  
DUE TO, OR AS A CONSEQUENCE OF:

(B) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF:

(C) \_\_\_\_\_

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH **6 months**

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A):

19A. DATE OF OPERATION **7/72**

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED **BIOPSY**

20A. AUTOPSY? (Yes or No) **NONE**

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) **(0)**

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that **(1)** (this hospital) attended the deceased from **December 6** 19 **72** to **December 6** 19 **72**, that **(1)** (we) last saw the deceased alive on **December 6** 19 **72** and that in **(1)** (our) opinion death occurred on the date and hour and from the causes stated above. **(1)** (We) (did) **(did not)** view the body after death.

23A. SIGNATURE **Barry Izenstein MD**

23B. DATE SIGNED **12-6-72**

23C. PHYSICIAN'S NAME (Type) **BARRY IZENSTEIN, M. D.**

23D. ADDRESS **VA Hospital, Baltimore, Md. 21218**

24A. BURIAL CREMATION, REMOVAL (Specify) **Burial**

24B. DATE **12/9/72**

24C. NAME OF CEMETERY OR CREMATORY **Woodlawn Cemetery**

24D. LOCATION (City, town, or county) (State) **Baltimore, Md.**

25A. DATE REC'D BY HEALTH DEPT. **DEC 8 1972**

25B. NAME OF REGISTRAR **Sidney [Signature]**

25C. FUNERAL DIRECTOR **Leonard J. Ruck Inc., Balto. Md. 21214**

ADDRESS \_\_\_\_\_

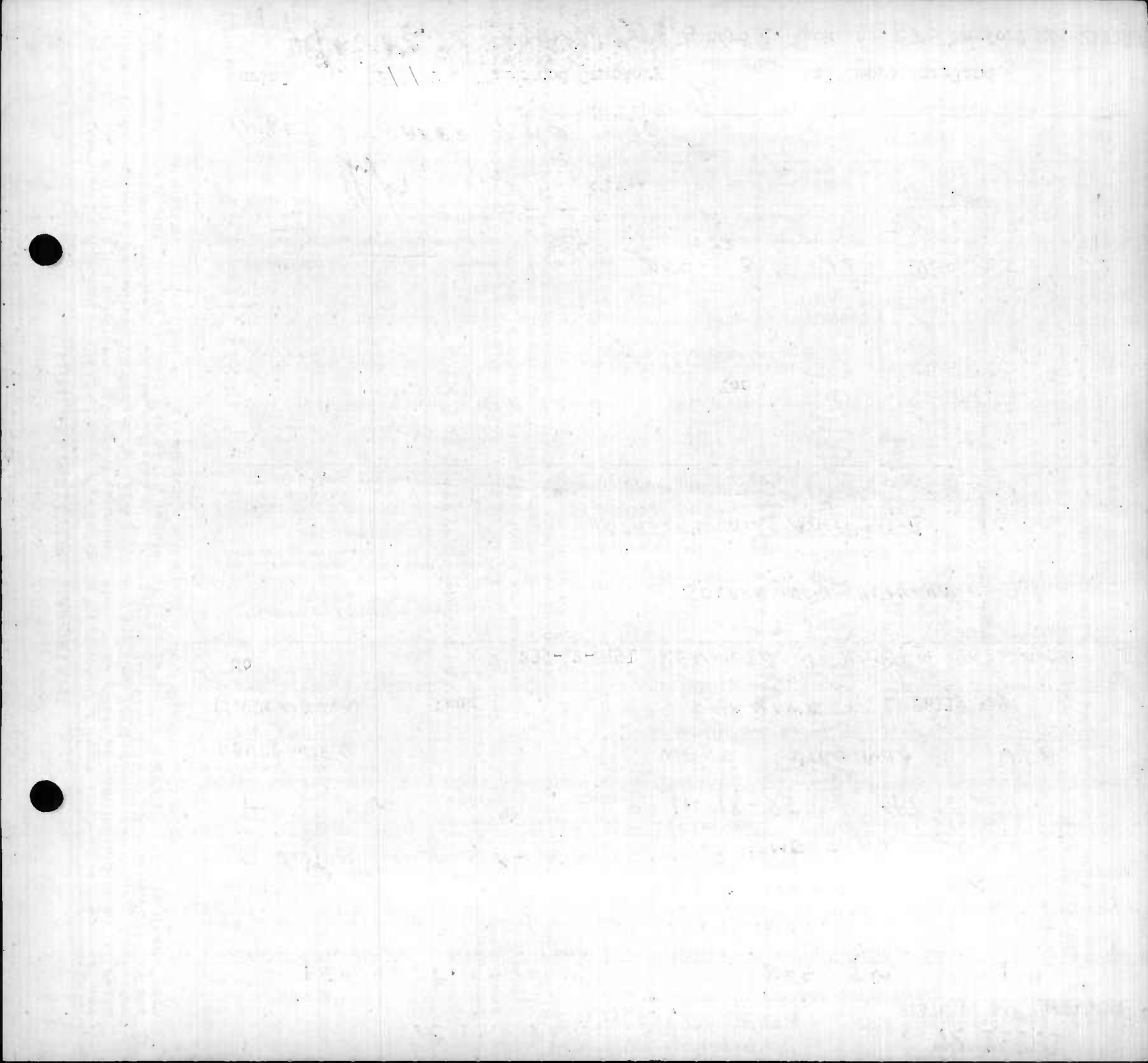




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 72 11623				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 11623	
CERTIFICATE OF DEATH				STATE OF MARYLAND-DEMD			
1. NAME OF DECEASED (Type or Print) <b>BERNICE B. DAWSON</b>				2. DATE AND HOUR OF DEATH <b>DEC 5TH 1.11 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>THE UNION MEMORIAL HOSP</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>905</b>			
5. SEX <b>F</b>		6. RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-18-25</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>UNKNOWN Louk</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN Dolly May</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>235-42-6791</b>		17. INFORMANT <b>KENNETH J. DAWSON</b>		ADDRESS <b>SAME</b>	
18. <b>430.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>II</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>SUBARACHNOID HEMORRAGE</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>INTRACRANEAL ANEURISM</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
19A. DATE OF OPERATION <b>2</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>DEC 3 1972</b> to <b>DEC 5 1972</b> , that (I) (we) last saw the deceased alive on <b>DEC 5 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Andres Suarez, M.D.</b>				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <b>ANDRES SUAREZ, M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/9/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Parkwood Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 8 1972</b>		25B. NAME OF REGISTRAR <b>Andrey Indostroy</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Rack Inc. 5305 Harford Rd. 21214</b>			



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 11624

BIRTH NO.

STATE OF MARYLAND-DEATH

1. NAME OF DECEASED (Type or Print) RICHARD S. CHATFIELD		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> December 7, 1972		Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 301 W. Lombard Street (Holiday Inn - Room #1124)		3. DATE PRONOUNCED DEAD Month Day Year December 7, 1972		Hour 8:50 A. M.	
6. SEX Male		7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 6/8/1900		10. AGE (in years lost birthday) 72		11. BIRTHPLACE (State or foreign country) Conn.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Frederick Chatfield		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Structural Engineer, Building	
15. MOTHER'S MAIDEN NAME Edith Smith		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes W W I		17. SOCIAL SECURITY NO. 084-10-7123	
18. INFORMANT Mrs. Ruby Chatfield		19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) No	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Marvin S. Platt, M.D. EXAMINER'S NAME (Type): Marvin S. Platt, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: December 7, 1972					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/9/72		24C. NAME of CEMETERY or CREMATORY Evergreen Cemetery	
24D. LOCATION (City, town, or county) (State) New Haven Conn		25A. DATE REC'D BY HEALTH DEPT. DEC 8 1972		25B. NAME OF REGISTRAR Leonard J. Ruck Inc.	
25C. FUNERAL DIRECTOR ADDRESS 5305 Harford Rd. 21214					

100-1

11/1

100

11

x

62-27-88 sab 1  
C-610

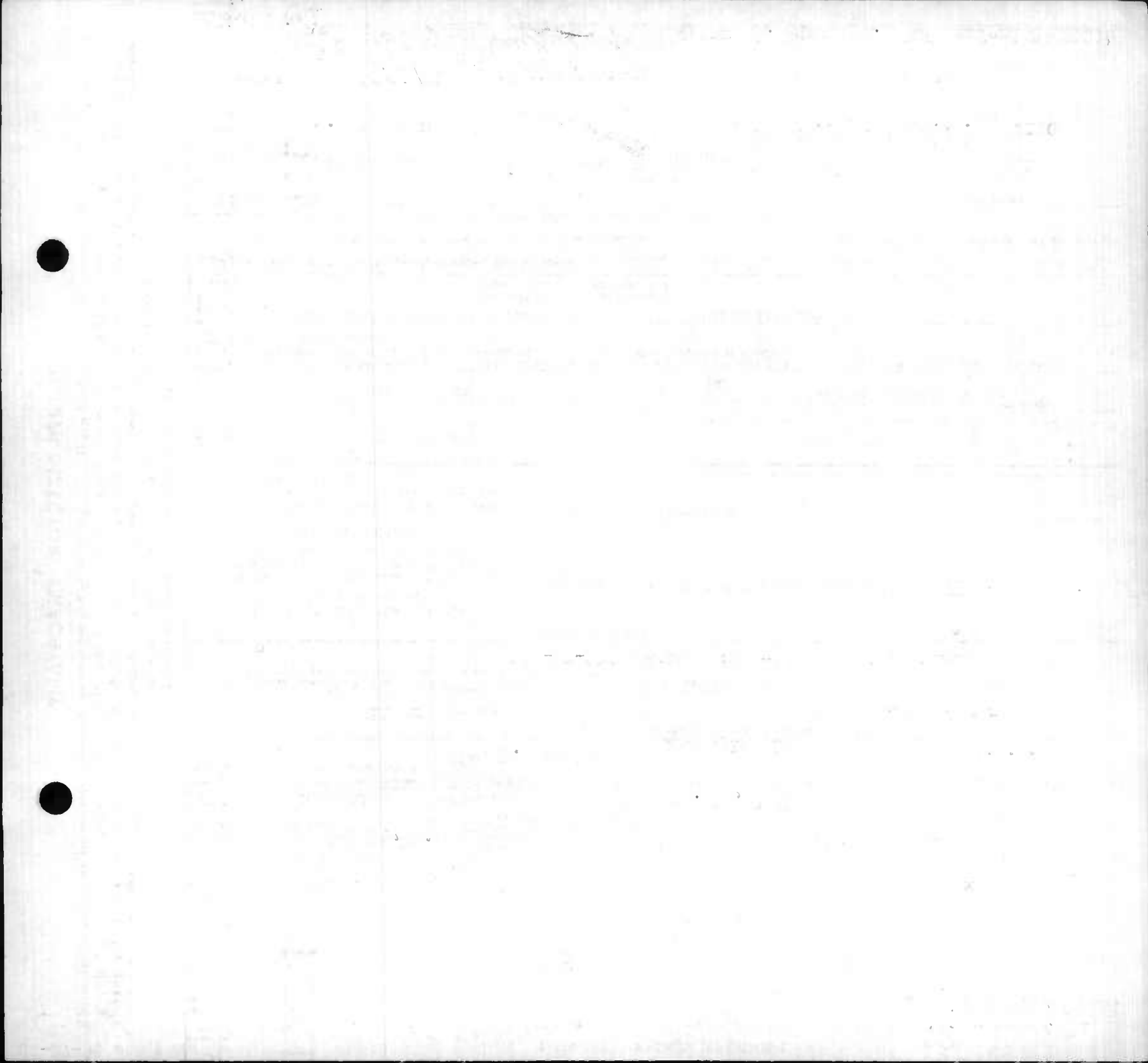
72 11625

CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHREG. NO. 72 11625  
STATE OF MARYLAND-DHMH

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Croop, Oliver</u>		2. DATE AND HOUR OF DEATH <u>12-6-72</u> <u>9:30</u> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2652</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>31</u> <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Md. 21224</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>Male</u>	6. RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 19, 1904</u>		9. AGE (in years last birthday) <u>68</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Glen L. Martin</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
13. FATHER'S NAME <u>Oliver Croop</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		14. SOCIAL SECURITY NO. <u>206-10-2300A</u>		17. INFORMANT ADDRESS <u>Records: BCH-4940 Eastern Avenue 21224</u>	
18. <u>710.91</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>(A) IMMEDIATE CAUSE Myocardial infarction 3 1/2 hrs</u> <u>(B) ASCVD</u> <u>(C)</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>11 30</u> 19 <u>72</u> to <u>12-6</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>12-6</u> 19 <u>72</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>J. Anderson MD</u> DEGREE				23B. DATE SIGNED <u>12-6-72</u>	
23C. PHYSICIAN'S NAME (Type) <u>J. Anderson, MD</u> DEGREE				23D. ADDRESS <u>Baltimore City Hospitals</u> <u>4940 Eastern Ave., Baltimore, Md. 21206</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/11/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Oaklawn Cemetery</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 8 1972</u>		25B. NAME OF REGISTRAR <u>Andrew H. Norton</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Rick Inc. 5305 Harford Rd 21214</u>	
24D. LOCATION (City, town, or county) <u>Baltimore Maryland</u>		(State)			

FUNERAL DIRECTOR: IMPORTANT

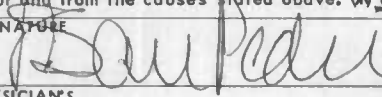
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 11626</b>	
BIRTH NO. <b>72 11626</b>				STATE OF MARYLAND-DHMH	
1. NAME OF DECEASED (Type or Print) <b>HACKETT, NETTIE LEE</b>			2. DATE AND HOUR OF DEATH <b>DECEMBER 6, 1972 7:40 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>40 ST AGNES HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>  C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  E. STREET AND NUMBER <b>1901 SHERWOOD RD - 21227</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>CAUCASIAN</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10 31 18</b>	9. AGE (In years last birthday) <b>54</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>GEORGE KNAUER</b>			14. MOTHER'S MAIDEN NAME <b>ETHEL MULES</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>215-18-9148</b>		17. INFORMANT ADDRESS <b>ST AGNES HOSPITAL RECORDS CATON &amp; WILKENS AVES BALTO MD 21229</b>
18. <b>486X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Renal shutdown (acute renal failure)</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Sepsis (undetermined bacteremia)</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Left lower pneumonia, R. lower pneumonia</b> (C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). _____					
19A. DATE OF OPERATION <b>2/1</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that <b>XX</b> (this hospital) attended the deceased from <b>11 20</b> 19 <b>72</b> to <b>12 06</b> 19 <b>72</b> , that <b>XX</b> (we) last saw the deceased alive on <b>12 06</b> 19 <b>72</b> and that in <b>XX</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>X</b> (We) (did) <b>XXXX</b> view the body after death.					
23A. SIGNATURE 				23B. DATE SIGNED <b>12/06/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>S SAN PEDRO, M.D.</b>				23D. ADDRESS <b>BALTIMORE, MD 21229 ST. AGNES HOSPITAL; CATON &amp; WILKENS AVES</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/9/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Dorsey, Howard, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 8 1972</b>			
25B. NAME OF REGISTRAR <b>Sidney H. [unclear]</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Antkro? Inc. 1328 Sulphur Rd.</b>			



2 JUN 1960 W.D.

21 VENEZ HOSPITAL CAYMAN & LITTON 21

BUTLIMORE NO 31333

130000

XX

13 00

33

XX

13 00

33

REC

WIKERS VARS BUTLIMORE NO 31333

21 VENEZ HOSPITAL CAYMAN & LITTON 21

RECEIVED KINREN

ETHER WAGES

WIREMILE

NAVYLAND

LEWIS CANNON

10 31 13

21

1301 250000 30 - 31333

21 VENEZ HOSPITAL

BUTLIMORE

NAVYLAND CAYMAN

RECEIVED KINREN

RECEIVED KINREN

1

H-600

BC 72-15627

BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 11627

BIRTH NO.

STATE OF MARYLAND - DEATH

REG. NO.

1. NAME OF DECEASED (Type or Print) Jennifer Love Hare		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 12 Day 5 Year 72 Hour	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 Union Memorial Hospital		3. DATE PRONOUNCED DEAD Month 12 Day 5 Year 72 Hour 11:25 a. m.	
6. SEX female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2749	
9. DATE OF BIRTH		10. AGE (in years lost birthday) 6 WKS	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Sudden death in infancy		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C)			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 12/6/72			
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE 12.5.72	
24C. NAME OF CEMETERY or CREMATORY UOFM ANATOMY BOARD		24D. LOCATION (City, town, or county) (State) BALT. MD	
25A. DATE REC'D BY HEALTH DEPT DEC 8 1972		25B. NAME OF REGISTRAR Sidney [Signature]	
25C. FUNERAL DIRECTOR Raymond J. Curran		ADDRESS 817 SCARLETT DR. TOLESON, MD 21204	

0

1725, 1941

1-110

WEATHER VESSEL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. 72 11628	
BIRTH NO. 72 11628				STATE OF MARYLAND - DEHE			
1. NAME OF DECEASED (Type or Print) HUTCHINS, JACK ANDREW				2. DATE AND HOUR OF DEATH DECEMBER 4, 1972 7:18 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST AGNES HOSPITAL CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229				MARYLAND HOWARD 21043		C. CITY OR TOWN D. INSIDE CITY LIMITS? ELLCOTT CITY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER 9806 GWYNN PARK DRIVE 6300				5. SEX MALE		6. RACE CAUCASIAN	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 12/09/13		9. AGE (In years last birthday) 58	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) XXXXXX CLERK				10B. KIND OF BUSINESS OR INDUSTRY EXPRESS CO		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME SYLVESTER HUTCHINS			
14. MOTHER'S MAIDEN NAME MARY CHANEY				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W W 2			
16. SOCIAL SECURITY NO. 216-10-4809				17. INFORMANT BALTO MD 21229			
18. 4309 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Hemorrhage, Subarachnoid, Spontaneous (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) Etiology Not Determined (C) DUE TO, OR AS A CONSEQUENCE OF: APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hrs.				19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/4 1972 to 11/23 1972, that (I) (we) last saw the deceased alive on 12/4 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Charles M. Henderson, MD				23B. DATE SIGNED 12/4/72		23C. PHYSICIAN'S NAME (Type) CHARLES M. HENDERSON, M.D.	
23D. ADDRESS WILKENS & PINE HEIGHTS AVES ST AGNES MEDICAL BUILDING #204				24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			
24B. DATE 12/08/72				24C. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE MEMORIAL PARK		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND 21227	
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1972				25B. NAME OF REGISTRAR Audrey H. [Signature]		25C. FUNERAL DIRECTOR HARRY H. WITZKE 4112 COLUMBIA PIKE OF HOWARD COUNTY ELLICOTT CITY, MD. 21043	

DECCA 100K

100K 100K

CHARLES W. HARRISON, N.D.

100K 100K

100K 100K

100K 100K

100K 100K

100K 100K

100K 100K

100K 100K

100K 100K

100K 100K

100K 100K

100K 100K

100K 100K

100K 100K

100K 100K

100K 100K

100K 100K

100K 100K

100K 100K

100K 100K

100K 100K

100K 100K

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 11629		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. 72 11629	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <u>Beehler, Clarence I.</u>			2. DATE AND HOUR OF DEATH <u>12/6/72</u> <u>5:00 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>1608</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Bon Secours Hospital</u>			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <u>4022 Cranston Avenue</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/18/95</u>	9. AGE (In years last birthday) <u>77</u>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>			11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Frederick Beehler</u>			14. MOTHER'S MAIDEN NAME <u>Carrie Shriner</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>015-07-6040</u>		17. INFORMANT <u>Mr. George Parkhurst, 1214 Munsey Bldg.</u>
18. <u>183X I</u> CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE <u>uremia</u> DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) <u>adenocarcinoma of prostate</u> DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			(C) _____		
19A. DATE OF OPERATION <u>Dec. 1, 72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>good condition</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Oct 26 1972</u> to <u>Dec 6 1972</u> that (I) <u>we</u> last saw the deceased alive on <u>Dec 6 1972</u> and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> (did) (did not) view the body after death.					
23A. SIGNATURE <u>CHOON JA AHN MD</u>			23B. DATE SIGNED <u>Dec 6 '72</u>		23C. PHYSICIAN'S NAME (Type) <u>CHOON JA AHN MD</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>12/9/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Lorraine Mausoleum</u>
24D. LOCATION <u>Baltimore, Maryland</u>			25A. DATE REC'D BY HEALTH DEPT. <u>DEC 8 1972</u>		
25B. NAME OF REGISTRAR <u>Witzke, 1630 Edmondson Avenue</u>			25C. FUNERAL DIRECTOR <u>Witzke, 1630 Edmondson Avenue</u>		





CITY HEALTH DEPARTMENT  
 CERTIFICATE OF DEATH

REG. NO.

72 11630

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MARTHA LONG

2. DATE AND HOUR OF DEATH

STATE OF MARYLAND - DEED

Dec-6, 1972 12 30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Baltimore City Hospitals

4940 Eastern Avenue

Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE B. COUNTY  
Maryland Baltimore

C. CITY OR TOWN

Dundalk

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

6614 Wood Park Drive 21222

5. SEX

Female

6. RACE

Caucasian

7. MARRIED ☐NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

17 Jan 92

9. AGE (In years last birthday)

80

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Alex Corl

14. MOTHER'S MAIDEN NAME

Burkette

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

ECH: RECORDS 4940 Eastern Avenue  
Baltimore, Maryland 21224

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

X X X X X X

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

10-15 yrs.

~10 yrs.

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE OLD INJURY OCCURRED

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)

21E. INJURY OCCURRED

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

 22. I certify that (1) ~~this hospital~~ attended the deceased from Dec 6 19 72 to DOA 19 72  
 that (1) (we) last saw the deceased alive on Dec 6 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

JAY E. MENITONE, MD

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

12/6/72

23C. PHYSICIAN'S NAME (Type)

JAY E. MENITONE, MD

23D. ADDRESS

4940 Eastern Avenue  
Baltimore, Maryland 21224

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

burial/remov. 8 Dec 72 Arlington National Cem. Arlington, Va.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

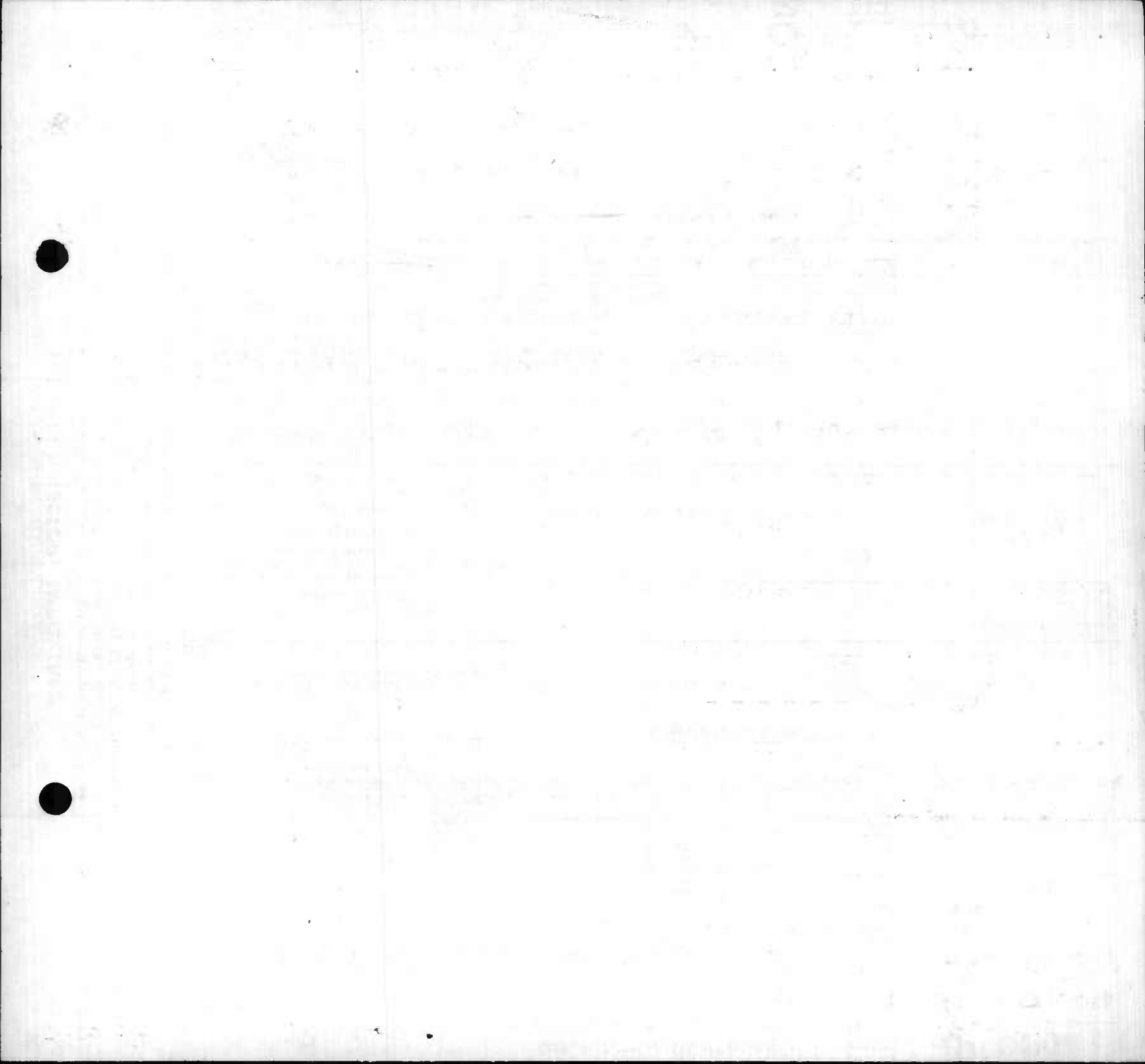
ADDRESS

DEC 8 1972

Arlington National Cem.

Ulrich Funeral Home, Dundalk, Md.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 11631</u>	
BIRTH NO. <u>72 11631</u>				STATE OF MARYLAND - DEPT. OF HEALTH	
1. NAME OF DECEASED (Type or Print) <u>Helen Adams Reightler</u>			2. DATE AND HOUR OF DEATH <u>11/30/72</u> <u>6:35</u> P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Maryland General Hospital</u> <u>48</u>			A. STATE <u>Md.</u> B. COUNTY <u>4 BALTO</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <u>1006 Cliff Place</u>			<u>21226</u>		
5. SEX <u>F</u> 6. RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-1-08</u> 9. AGE (In years last birthday) <u>64</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>James Biscoe</u>		14. MOTHER'S MAIDEN NAME <u>Sarah A Ellis</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-10-7627</u>		17. INFORMANT <u>Earl J. Reightler</u> ADDRESS <u>1007 Fieldstone Rd.</u>	
18. <u>412.2 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Intracerebral Hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Hypertensive Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 days</u>			II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At <input type="checkbox"/> Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>11-27</u> 19 <u>72</u> to <u>11-30</u> 19 <u>72</u> that (I) <u>(we)</u> last saw the deceased alive on <u>11-30</u> 19 <u>72</u> and that (I) <u>(my)</u> <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE <u>Arnold G. Alexander MD</u> DEGREE				23B. DATE SIGNED <u>11-30-72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Arnold G. Alexander MD</u> DEGREE				23D. ADDRESS <u>827 Linden Ave Balt, Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/4/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial Park</u>	
24D. LOCATION <u>Glen Burnie Anne Arundel Md</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 8 1972</u>			
25B. NAME OF REGISTRAR <u>Sydney H. Horton</u>		25C. FUNERAL DIRECTOR <u>Mc Guffey Funeral Home</u> ADDRESS <u>Mt. &amp; Tick Neck Rds</u>			

1. The first part of the report is a general description of the project. It includes the title, the objectives, the scope, and the organization of the report. The title is "The Effect of Temperature on the Rate of Reaction of Hydrogen Peroxide with Potassium Iodide". The objectives are to determine the effect of temperature on the rate of reaction and to determine the activation energy of the reaction. The scope is limited to the reaction of hydrogen peroxide with potassium iodide in aqueous solution. The organization of the report is as follows: Introduction, Experimental, Results, Discussion, and Conclusion.

2. The second part of the report is a description of the experimental procedure. It includes the materials and apparatus used, the procedure followed, and the results obtained. The materials and apparatus used are hydrogen peroxide, potassium iodide, sulfuric acid, and a water bath. The procedure followed is to prepare a series of solutions of hydrogen peroxide and potassium iodide at different temperatures and to measure the time taken for the reaction to occur. The results obtained are that the rate of reaction increases with increasing temperature.

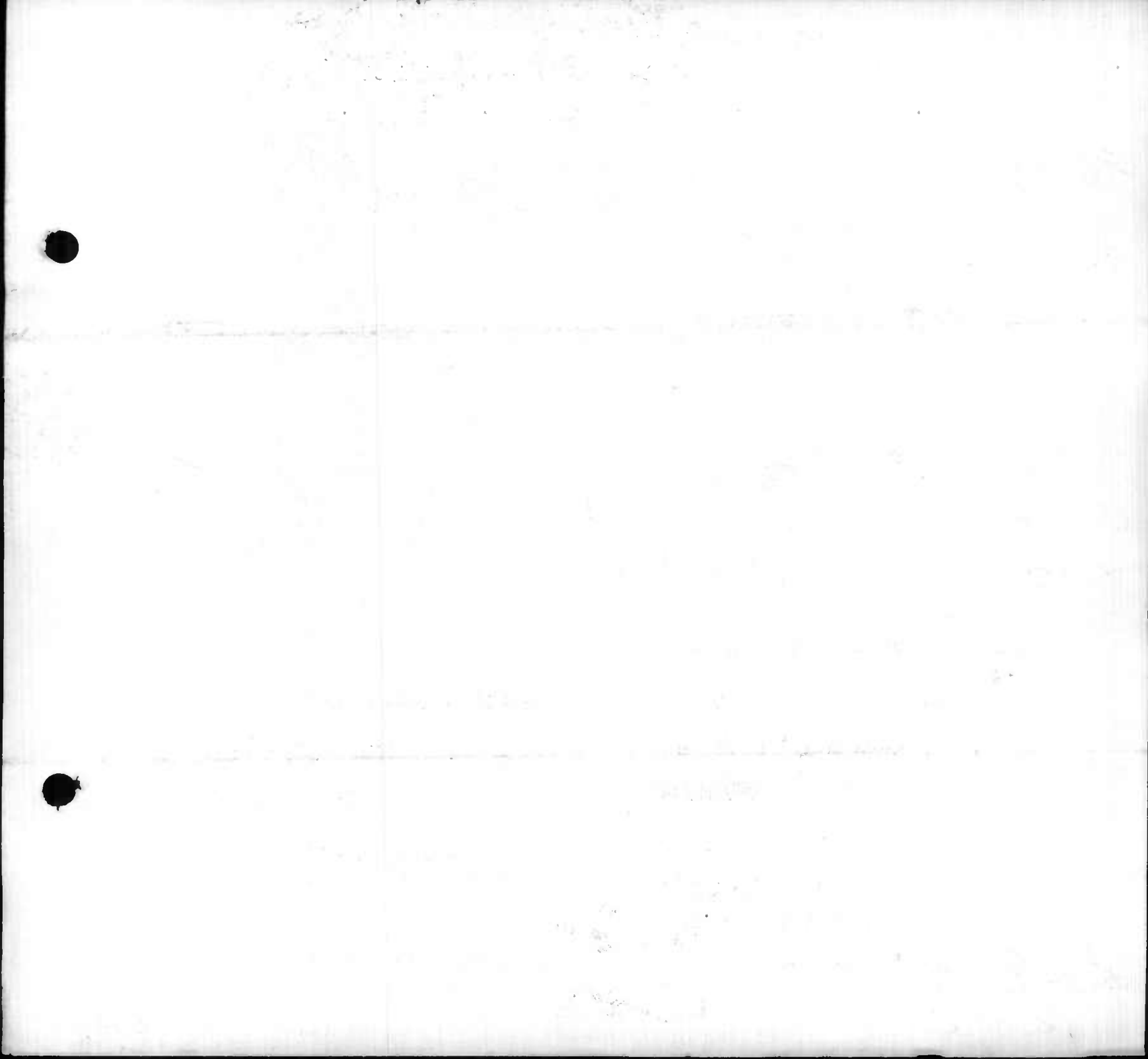
3. The third part of the report is a discussion of the results. It includes a comparison of the results with those obtained by other workers, a discussion of the factors which affect the rate of reaction, and a determination of the activation energy of the reaction. The results obtained are compared with those obtained by other workers and it is found that they are in good agreement. The factors which affect the rate of reaction are discussed and it is found that the rate of reaction is affected by temperature, concentration, and the presence of a catalyst. The activation energy of the reaction is determined to be 50 kJ/mol.

4. The fourth part of the report is a conclusion. It summarizes the results of the experiment and states the conclusions drawn from them. The results of the experiment are that the rate of reaction increases with increasing temperature and that the activation energy of the reaction is 50 kJ/mol. The conclusions drawn from these results are that the rate of reaction is affected by temperature and that the activation energy of the reaction can be determined from the rate of reaction.

5. The fifth part of the report is a list of references. It includes the names of the authors, the titles of the papers, and the names of the journals or books in which the papers were published. The references are as follows: 1. "The Effect of Temperature on the Rate of Reaction of Hydrogen Peroxide with Potassium Iodide", J. Chem. Soc., 1950, 1234. 2. "The Effect of Concentration on the Rate of Reaction of Hydrogen Peroxide with Potassium Iodide", J. Chem. Soc., 1951, 1235. 3. "The Effect of a Catalyst on the Rate of Reaction of Hydrogen Peroxide with Potassium Iodide", J. Chem. Soc., 1952, 1236.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-4621		72 11632		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 11632	
BIRTH NO.				STATE OF MARYLAND - BALTIMORE			
1. NAME OF DECEASED (Type or Print) Sister Mary Alice Clark				2. DATE AND HOUR OF DEATH December 5, 1972 10:30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 94 Visitation Convent 5712 Roland ave		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		A. STATE Md.		B. COUNTY Baltimore	
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 5712 Roland Ave			
5. SEX Female		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/10/94	
						9. AGE (in years last birthday) 78	
						10. Under 1 Yr. Months Days 11 Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Religious Nun				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Brooklyn, New York	
13. FATHER'S NAME John Matthew Clark				14. MOTHER'S MAIDEN NAME Eliz Mangen			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT Mother Marie Teresa	
						ADDRESS same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 721 X I CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: C.H. 7 (B) DUE TO, OR AS A CONSEQUENCE OF: Pagets Disease of 10 years TONE (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 10 years			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1966 to Dec 5 1972 that (I) (we) last saw the deceased alive on Dec 5 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Dr. William G. Helfrich				23B. DATE SIGNED 6 Dec 72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS 5006 Roland Ave.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/7/72		24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Frederick Rd Balto Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1972		25B. NAME OF REGISTRAR Sidney H. Heston		25C. FUNERAL DIRECTOR Mitchell Wiedefeld Home		ADDRESS 6500 York Rd	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 11633

REG. NO.

BIRTH NO.

STATE OF MARYLAND

1. NAME OF DECEASED  
(Type or Print)

PAULINE MORGAN

2. DATE OF DEATH  
Known ☒ Month Day Year Hour  
Estimated ☐ M.4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF HOSPITAL OR INSTITUTION  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

44 Union Memorial Hospital

3. DATE PRONOUNCED DEAD Month Day Year Hour  
12 4 1972 8:50a M.5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE Md. B. COUNTY 1205

6. SEX

female

7. RACE

white

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

March 6, 1932

10. AGE (In years last birthday)

40

11. Under 1 Yr. 11 Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

1714 St. Paul St.

11. BIRTHPLACE (State or foreign country)

Tennessee

12. CITIZEN OF WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

Martin McDaniel

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Beatrice Harrison

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  
NO

17. SOCIAL SECURITY NO.

18. INFORMANT ADDRESS  
J. Austin Dillon Funeral Home  
502 Pryor St. S.W. Atlanta, Georgia

19.

CAUSE OF DEATH:

Cerebral hypoxia and bronchopneumonia

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Ingestion of Valium and other unidentifiable medications

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  
Home

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

1714 St. Paul Street

22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)  
12-4-72 A. m.

22E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

22F. HOW DID INJURY OCCUR?

Ingested overdose of drugs

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL SIGNATURE  
EXAMINER'S NAME (Type)

Russell S. Fisher, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-4-72

24A. BURIAL CREMATION, REMOVAL (Specify)

Removal

24B. DATE

12/6/72

24C. NAME of CEMETERY or CREMATORY

Tara Memorial Gardens

24D. LOCATION (City, town, or county) (State)

Rex Clayton, Georgia

25A. DATE REC'D BY HEALTH DEPT.

DEC 8 1972

25B. NAME OF REGISTRAR

Sidney W. Kestner

25C. FUNERAL DIRECTOR

Robert C. Altenburg Funeral Home, Inc.  
6009 Harford Rd. Balto., Md. 21214

ADDRESS





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 11634	
72 11634 CERTIFICATE OF DEATH					
BIRTH NO.		STATE OF MARYLAND-DHMH			
1. NAME OF DECEASED (Type or Print) <b>EDWARD J. BUDACZ SR.</b>		2. DATE AND HOUR OF DEATH <b>12/6/72 205 P.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>103</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>37 MERCY HOSPITAL</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>512 S. LAKEWOOD AVE</b>					
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC. 2 1907</b>	9. AGE (In years last birthday) <b>65</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>POLICEMAN</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>RET.</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>ANDREW BUDACZ</b>		14. MOTHER'S MAIDEN NAME <b>?</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216-03-5249</b>		17. INFORMANT <b>MR. DONALD BUDACZ</b>	
		ADDRESS <b>3485 BUCKNELL RD</b>			
18. <b>410.9 I</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Acute myocardial Infarction 12 hr</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>ASCUD</b>		<b>Yrs.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Autic insufficiency, mitral insufficiency, old myocardial infarction</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE OLD INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>11/25</b> 19 <b>72</b> to <b>12/6</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>12/6</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>James S. Dwyer</b>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>12/6/72</b>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <b>DEGREE</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12/9/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>SACRED HEART CEMETERY</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE C. MD.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 8 1972</b>		25B. NAME OF REGISTRAR <b> Sidney W. ...</b>		25C. FUNERAL DIRECTOR <b> ROYAL ...</b>	
		ADDRESS <b>KACZOROWSKI 2525 FLEET ST.</b>			

THE UNIVERSITY OF CHICAGO  
LIBRARY

1911

1912

1913

1914

1915

1916

1917

1918

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

72 11635  
STATE OF MARYLAND-DHM

BIRTH NO.

72 11635

1. NAME OF DECEASED

(Type or Print)

Szczepaniak, Catherine

2. DATE AND HOUR OF DEATH

12-3-72

1 30 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Maryland  
General Hosp

48

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md

BALTO 5300

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

Franklin Ave. 630

5. SEX

F

6. RACE

W

7. MARRIED ☐NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

11-08-86

9. AGE (In years last birthday)

86

10. Under 1 Yr. Months Days

11. Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

VINCENT MADRAK

14. MOTHER'S MAIDEN NAME

KATHERINE MAKOWSKA

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

216-09-2416

17. INFORMANT

Son

630 Franklin Ave ADDRESS

Balt. Md. 21221

18. 427.0 I

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Pneumonia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO, OR AS A CONSEQUENCE OF:

Congestive heart failure

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11-27 1972 to 12-3 1972 that (I) (we) last saw the deceased alive on 12-3 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Arnold G. Alexander M.D.

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

12-3-72

23C. PHYSICIAN'S NAME (Type)

Arnold G. Alexander M.D.

23D. ADDRESS

827 Linden Ave. 21201

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

12/6/72

24C. NAME OF CEMETERY OR CREMATORY

ST. STANISLAUS CEMETERY

24D. LOCATION

(City, town, or county)

(State)

MD.

25A. DATE REC'D BY HEALTH DEPT.

DEC 8 1972

25B. NAME OF REGISTRAR

Wendy Whitman

25C. FUNERAL DIRECTOR

Raymond R. KACZOROWSKI

25D. ADDRESS

2525 Fleet St

Am. ... ..

...

...

X

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

X

...

...

...

...

...

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 11636		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 11636 STATE OF MARYLAND	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		CHENOWETH, WILLIAM, E.		12-4-72 9:20 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		Md		103	
CHURCH HOME & HOSPITAL		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
35		E. STREET AND NUMBER 2424 FLEET ST.			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-05-10	9. AGE (In years last birthday) 62	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER		10B. KIND OF BUSINESS OR INDUSTRY MD. NAT'L BANK		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME JOHN CHENOWETH		14. MOTHER'S MAIDEN NAME HALLIE RHODES		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-12-0216		17. INFORMANT FLORENCE L. CHENOWETH ADDRESS 2424 FLEET ST. 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH Cardiopulmonary arrest. acute pulmonary edema. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute sub-coronary occlusion. Arteriosclerotic Cardiovascular disease. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-29-1972 to 12-4-1972 that (I) last saw the deceased alive on 12-4-1972 and that in my opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jung Ho Kim, M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12-4-72	
23C. PHYSICIAN'S NAME (Type) R. GOCO M.D.		23D. ADDRESS CHURCH HOME & HOSPITAL BALTIMORE, Md. 21231.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 12/7/72	24C. NAME OF CEMETERY or CREMATORY OAKLAWN CEMETERY		24D. LOCATION (City, town, or county) (State) BALTIMORE Co. MD.	
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1972		25B. NAME OF REGISTRAR Andrew Johnson		25C. FUNERAL DIRECTOR RAYMOND L. KACZOROWSKI 3525 FLEET ST.	

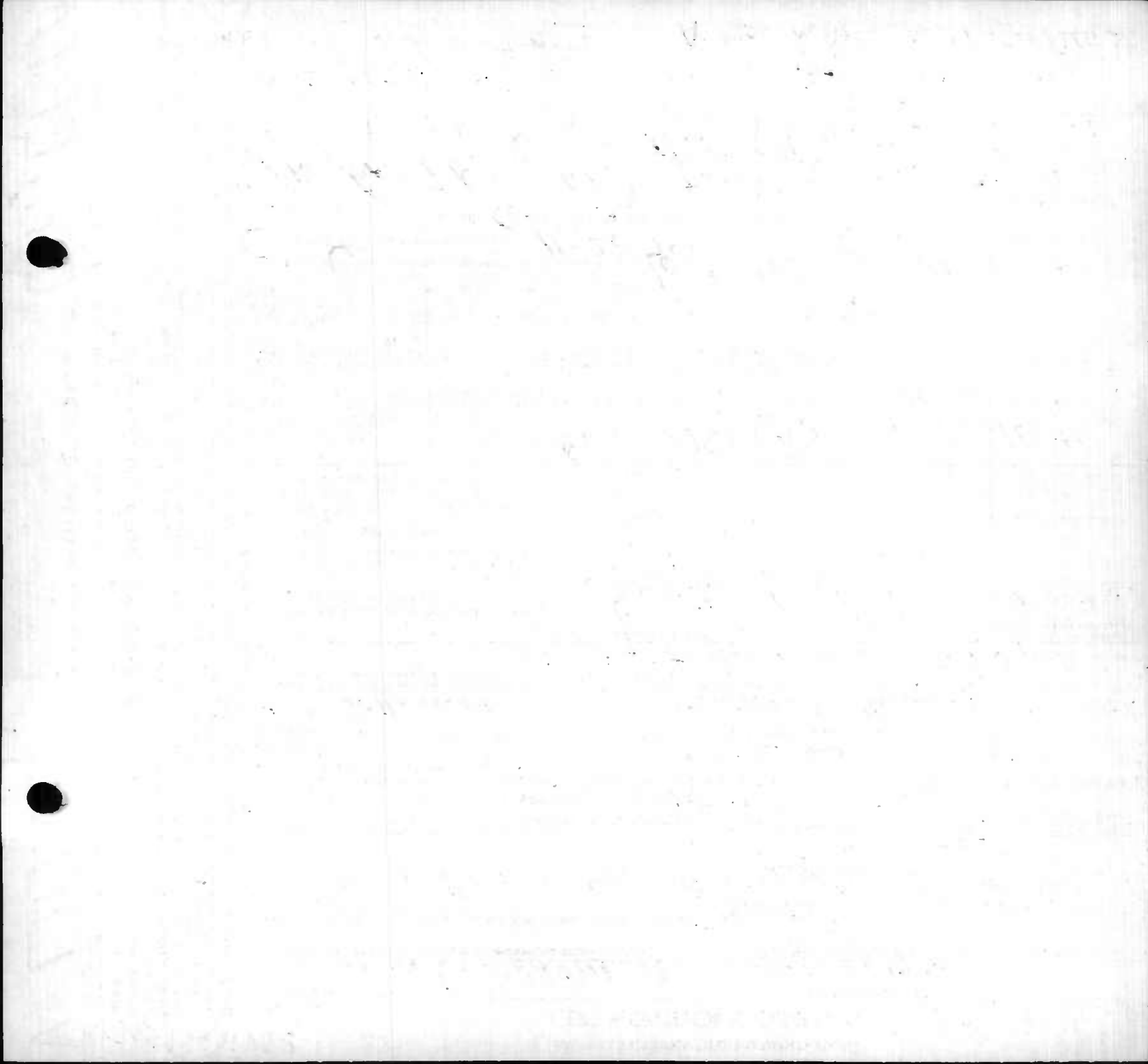
AS 17990



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 11637</u>	
CERTIFICATE OF DEATH					
BIRTH NO. <u>72 11637</u>		STATE OF MARYLAND-DEME			
1. NAME OF DECEASED (Type or Print) <u>JOHN P. SCHNAUFER</u>		2. DATE AND HOUR OF DEATH <u>DEC. 5, 1972</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>00 2501 FOSTER AVE</u>		A. STATE <u>MARYLAND</u>		B. COUNTY <u>103</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>2501 FOSTER AVE</u>			
5. SEX <u>M.</u>	6. RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 31, 1890</u>	9. AGE (In years last birthday) <u>82 yrs.</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>JOHN P. SCHNAUFER</u>		14. MOTHER'S MAIDEN NAME <u>GERTRUDE NORWOOD SCHNAUFER</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218-098480</u>		17. INFORMANT ADDRESS <u>MR. MELVIN HOOVER 705 S. MILTON AVE</u>	
18. <u>412.4 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Consecutive Heart Failure</u>		CAUSE OF DEATH (A) IN MEDICAL CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Consecutive Heart Failure</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2-3 mos</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Gen ASCVD</u>		10 +			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>10-9-72</u> 19 to <u>12-5-72</u> 19, that (I) (we) last saw the deceased alive on <u>11-28-72</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Theodore T. Niznik</u>				23B. DATE SIGNED <u>12-8-72</u>	
23C. PHYSICIAN'S NAME (Type) <u>T. NIZNIK</u>				23D. ADDRESS <u>429 S. Chester St 21231</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>12/8/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>MT. CARMEL CEMETERY</u>	
24D. LOCATION <u>BALTIMORE MD.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 8 1972</u>			
25B. NAME OF REGISTRAR <u>Raymond K. Kaczorowski</u>		25C. FUNERAL DIRECTOR ADDRESS <u>2525 FLEET ST.</u>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO.

72 11638

STATE OF MARYLAND-DEMD

BIRTH NO. 72 11638

1. NAME OF DECEASED

(Type or Print)

BROWN, DOLORA (DELORES)

2. DATE AND HOUR OF DEATH

12-6-72

8:55A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

46 LUTHERAN Hospital  
Baltimore, Md. 21216

4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

629 LINNARD St.

5. SEX

7

6. RACE

B

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

11-24-04

9. AGE (In years last birthday)

68

10. Under 1 Yr.

Months Days

11. Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Walter Jenkins

14. MOTHER'S MAIDEN NAME

Mollie Browser

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

238-38-9160

17. INFORMANT

CORINE Johnson

(Daughter)

ADDRESS

Same

18. 436.0 17250.9  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

I (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Acute Cardiorespiratory

Arrest

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Cerebrovascular accident

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

5 min.

50 days

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

High BP, Diabetes

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH Indefinite medical examiner

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐Not-While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10/10/1972 to 12/6/1972 that (I) (we) last saw the deceased alive on 12/6/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (not) view the body after death.

23A. SIGNATURE

S. S. DONGRE

DEGREE

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

12/6/72

23C. PHYSICIAN'S NAME (Type)

S. S. DONGRE

23D. ADDRESS

730, Ashburton St. Balto. Md. 21216

24A. BURIAL CREMATION, REMOVAL (Specify)

12-11-72

24B. DATE

BURIAL

24C. NAME OF CEMETERY or CREMATORY

CEDAR HILL CEM.

24D. LOCATION (City, town, or county)

ANNE ARUNDEL CTY. MD.

25A. DATE REC'D BY HEALTH DEPT.

DEC 8 1972

25B. NAME OF REGISTRAR

Sidney [Signature]

25C. FUNERAL DIRECTOR

Wm. C. March

ADDRESS

928 E. North Ave.



K-000

72 11639

BALTIMORE CITY HEALTH DEPARTMENT

72 11639

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. STATE OF MARYLAND-D.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) R. Claude Kee		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 12 6 72 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 46 Lutheran Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 6 72 6:45 a. M.	
6. SEX male		7. RACE White Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 11-11-23		10. AGE (In years last birthday) 49	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII		17. SOCIAL SECURITY NO. 225-22-5016	
18. INFORMANT Thelma L. Kee		ADDRESS 3103 Brighton Street	
19. 571.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Fatty metamorphosis of liver ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/6/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/11/72	
24C. NAME of CEMETERY or CREMATORY Cedar Hill Cemetery		24D. LOCATION (City, town, or county) (State) Anne Arundel Cty., Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1972		25B. NAME OF REGISTRAR Sidney [Signature]	
25C. FUNERAL DIRECTOR Wm. C. March		ADDRESS 928 E. North Ave	



1  
B-252

BALTIMORE CITY HEALTH DEPARTMENT

72 11640  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type Mr, MRS, etc.)		MICHELLE BOUKNIGHT		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year December 6, 1972		Hour 8:25 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				3. DATE PRONOUNCED DEAD		Month Day Year December 6, 1972		Hour 8:25 A. M.	
38 University Hospital				5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		A. STATE		B. COUNTY	
6. SEX Female		7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 4-3-72		10. AGE (In years last birthday) 8		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME CHRISTIE BOUKNIGHT	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				14B. KIND OF BUSINESS OR INDUSTRY INFANT		15. MOTHER'S MAIDEN NAME MARGARET FLEMINGS			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				17. SOCIAL SECURITY NO. INFANT		18. INFORMANT CHRISTIE BOUKNIGHT 801 MCKEAN AVENUE			

19. 282.5 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Interstitial pneumonia DUE TO, OR AS A CONSEQUENCE OF:  (B) Sickle cell crisis DUE TO, OR AS A CONSEQUENCE OF:  (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					

20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	

23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Marvin S. Platt, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
				DATE SIGNED December 7, 1972	

24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-9-72		24C. NAME of CEMETERY or CREMATORY MOUNT AUBURN CEMETERY		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1972		25B. NAME OF REGISTRAR Sidney [Signature]		25C. FUNERAL DIRECTOR MORTON & DYEETT FUNERAL HOME		ADDRESS 1701 LAURENS ST.	



1-5-1973 - Completion of cause of death on a pending medical examiner death  
certificate - Marvin S. Platt, M.D.      hs

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or print) <b>(ANDRE) Andera Hedgepath (HETGES PETH)</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month <b>12</b> Day <b>5</b> Year <b>72</b> Hour <b>M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>46 Lutheran Hospital</b>		3. DATE PRONOUNCED DEAD Month <b>12</b> Day <b>5</b> Year <b>72</b> Hour <b>7:20 p.</b> M.	
6. SEX <b>male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>4-23-55</b>		10. AGE (In years last birthday) <b>17</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME <b>ROSA HEDGEPATH</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>N/A</b>		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>ROSA WILSON</b>		ADDRESS <b>1504 SMALLWOOD STREET</b>	
19. <b>E 965 X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH <b>Gunshot wounds of chest</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C)	
20A. DATE OF OPERATION <b>12</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>	
22D. TIME OF INJURY (APPROX.) Month <b>12</b> Day <b>5</b> Year <b>72</b> Hour <b>7:05</b> P.M.		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? <b>1300 Block Bentalou St.</b>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Subject shot by unknown assailant</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Peter Lipkovic, M.D.</b> EXAMINER'S NAME (Type)  CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>12/6/72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12-8-72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>MOUNT CALVERY CEMETERY</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 8 1972</b>		25B. NAME OF REGISTRAR <b>Audrey Johnston</b>	
25C. FUNERAL DIRECTOR <b>MORTON &amp; DYETT F. H.</b>		ADDRESS <b>1701 LAURENS ST.</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## CERTIFICATE OF DEATH

BIRTH NO. 72 11612

1. NAME OF DECEASED  
(Type or Print)

Carlton Blanche

2. DATE AND HOUR OF DEATH

7<sup>30</sup> a.m. 12/6/72

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Baltimore City Hospitals

4940 Eastern Avenue

Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

2313 Anoka Avenue 21215

5. SEX

Male

6. RACE

Negro

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

8-5-1918

9. AGE (In years  
last birthday)

54

10. Under 1 Yr.  
Months11. Under 24 Hrs.  
Days

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Trinidad, B.W.I.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Malcolm

BLANCHE

14. MOTHER'S MAIDEN NAME

Agnes ?

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

17. INFORMANT

BCH: RECORDS Baltimore, Maryland 21224

18. 269.7 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/2/72 19 to 12/6/72 19  
that (I) (we) last saw the deceased alive on 12/6/72 19 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Michael J. Zinner M.D.

DEGREE

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

12/6/72

23C. PHYSICIAN'S  
NAME (Type)

MICHAEL J. ZINNER

DEGREE

23D. ADDRESS

4940 Eastern Avenue  
Baltimore, Maryland 2122424A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

12-8-72

24C. NAME of CEMETERY or CREMATORY

MOUNT AUBURN CEMETERY

24D. LOCATION

(City, town, or county)

BALTIMORE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.

DEC 8 1972

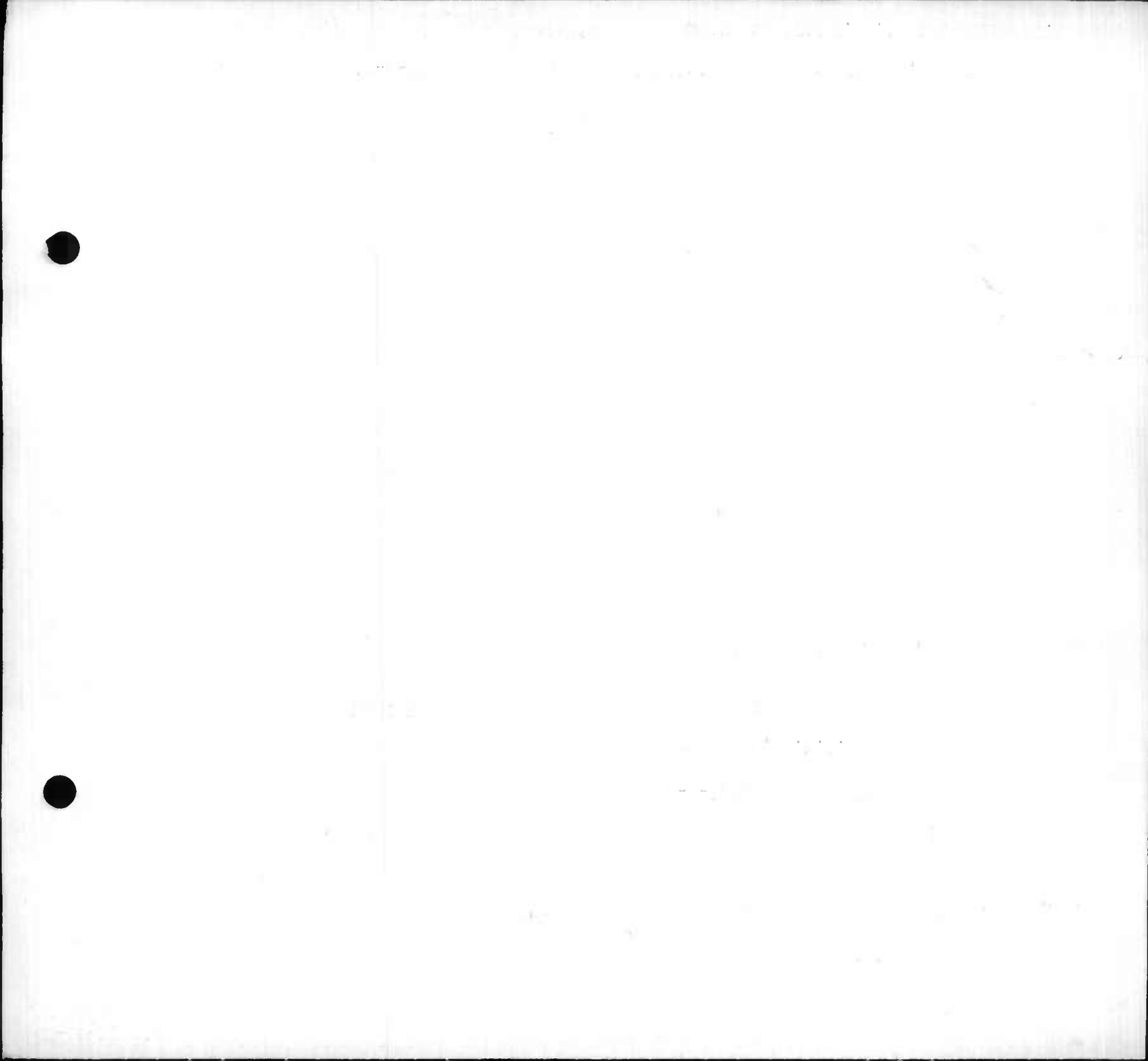
25B. NAME OF REGISTRAR

Sidney H. Hooton

25C. FUNERAL DIRECTOR

MORTON &amp; DYETT F. H. 1701 LAURENS ST.

ADDRESS



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 11643</u>	
BIRTH NO. <u>72 11643</u>				STATE OF MARYLAND-DHMH	
1. NAME OF DECEASED (Type or Print) <u>RICHARDSON, GERTRUDE</u>			2. DATE AND HOUR OF DEATH <u>12/6/72</u> <u>6:05 P. M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>md</u> B. COUNTY <u>Baltimore</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>42 Sinai Hospital Baltimore</u>			C. CITY OR TOWN <u>Balto</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <u>3435 Dupont Ave</u>		
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/4/20</u>	9. AGE (In years last birthday) <u>52</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <u>maid</u>		11. BIRTHPLACE (State or foreign country) <u>Balto Md</u>	
13. FATHER'S NAME <u>Willis Smith</u>		14. MOTHER'S MAIDEN NAME <u>Cora Brooks</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-22-1465</u>	17. INFORMANT <u>Eva Todd</u>		ADDRESS <u>-3435-Dupont Ave</u>
18. <u>410.9 14154.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Acute pulm. edema</u>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute MI</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF: <u>CA of the rectum</u> <u>Cachexia</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>one day</u> <u>one day</u> <u>at least one yr.</u>		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12/6/72</u> to <u>12/6/72</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>12/6/72</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Adriano 9020 S. J.</u>				23B. DATE SIGNED <u>12/6/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>A.C. DIJAMCO M.D.</u>				23D. ADDRESS <u>Sinai Hospital Baltimore</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-11-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Auburn Cem, Balto, Md</u>	
24D. LOCATION (City, town, or county) (State) <u>Balto, Md</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 8 1972</u>		25B. NAME OF REGISTRAR <u>Sidney Weston</u>	
25C. FUNERAL DIRECTOR <u>Dyett F. H. - Hauvens</u>		ADDRESS <u>St</u>			

[illegible]



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 72 11614  
STATE OF MARYLAND-DECEASED

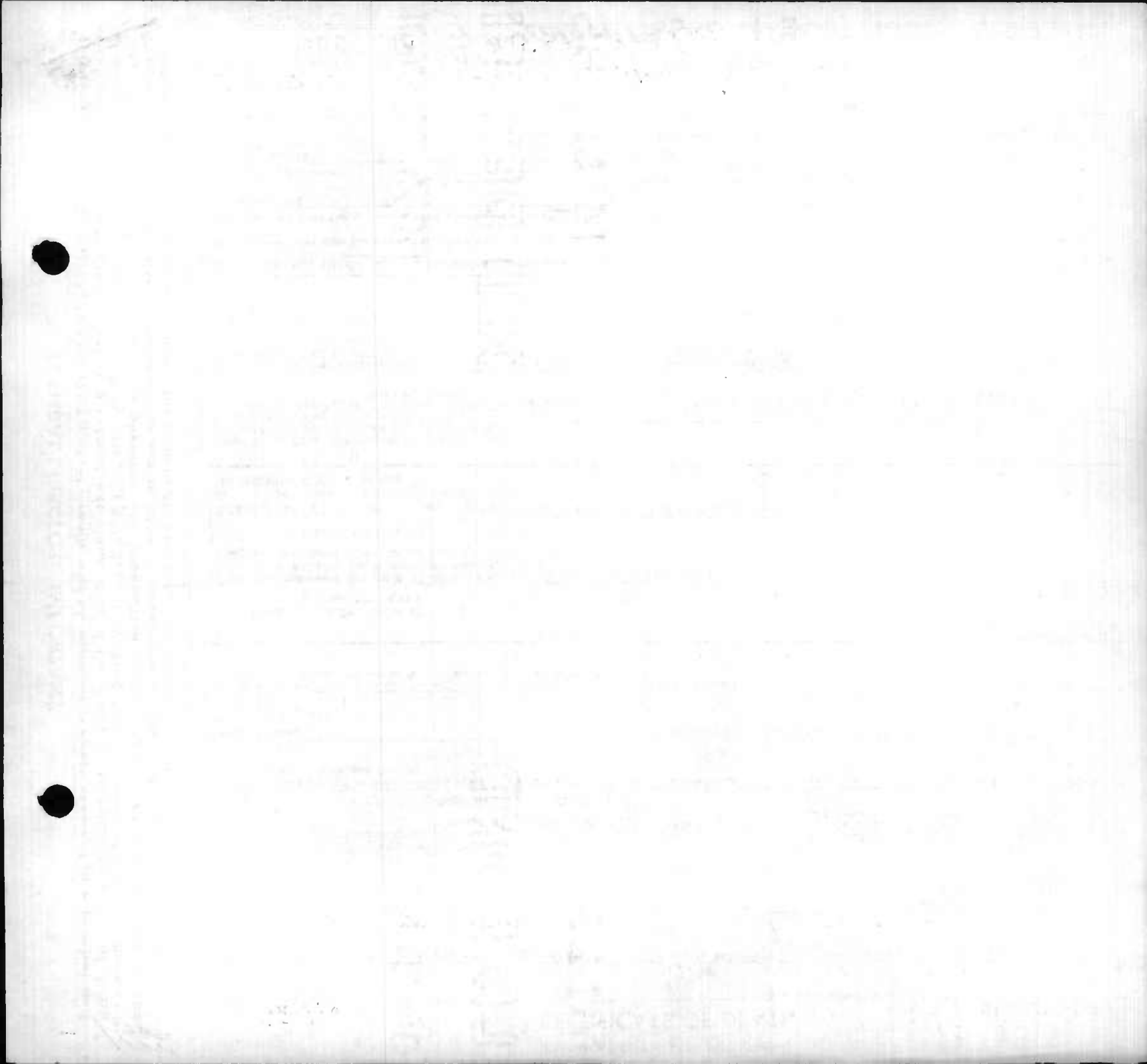
BIRTH NO. 72 11614		2. DATE AND HOUR OF DEATH # 12/6/72 11:05 A.M.	
1. NAME OF DECEASED (Type or Print) Bridges, Leroy		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 The Johns Hopkins Hospital		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male 6. RACE Negro 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/6/33 9. AGE (In years last birthday) 39	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) BALTO CITY BALTIMORE, MARYLAND	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Bridges		14. MOTHER'S MAIDEN NAME Maggie Carraway	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-30-3295	
17. INFORMANT MRS. BEATRICE HORNE 3425 DOEFIELD AVENUE		ADDRESS	
18. 593.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE Ventricular fibrillation 20 mins. (B) Renal failure, metabolic acidosis 10 days (C) _____ DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/26 1972 to 12/6 1972, that (I) (we) last saw the deceased alive on 12/6 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Robert Friedman		23B. DATE SIGNED 12/6/72	
23C. PHYSICIAN'S NAME (Type) Robert Friedman, M.D.		23D. ADDRESS The Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-9-72	
24C. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		24D. LOCATION (City, town, or county) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1972		25B. NAME OF REGISTRAR Sidney L. [Signature]	
25C. FUNERAL DIRECTOR ADDRESS MORTON & DYETT F. H. 1701 LAURENS ST.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

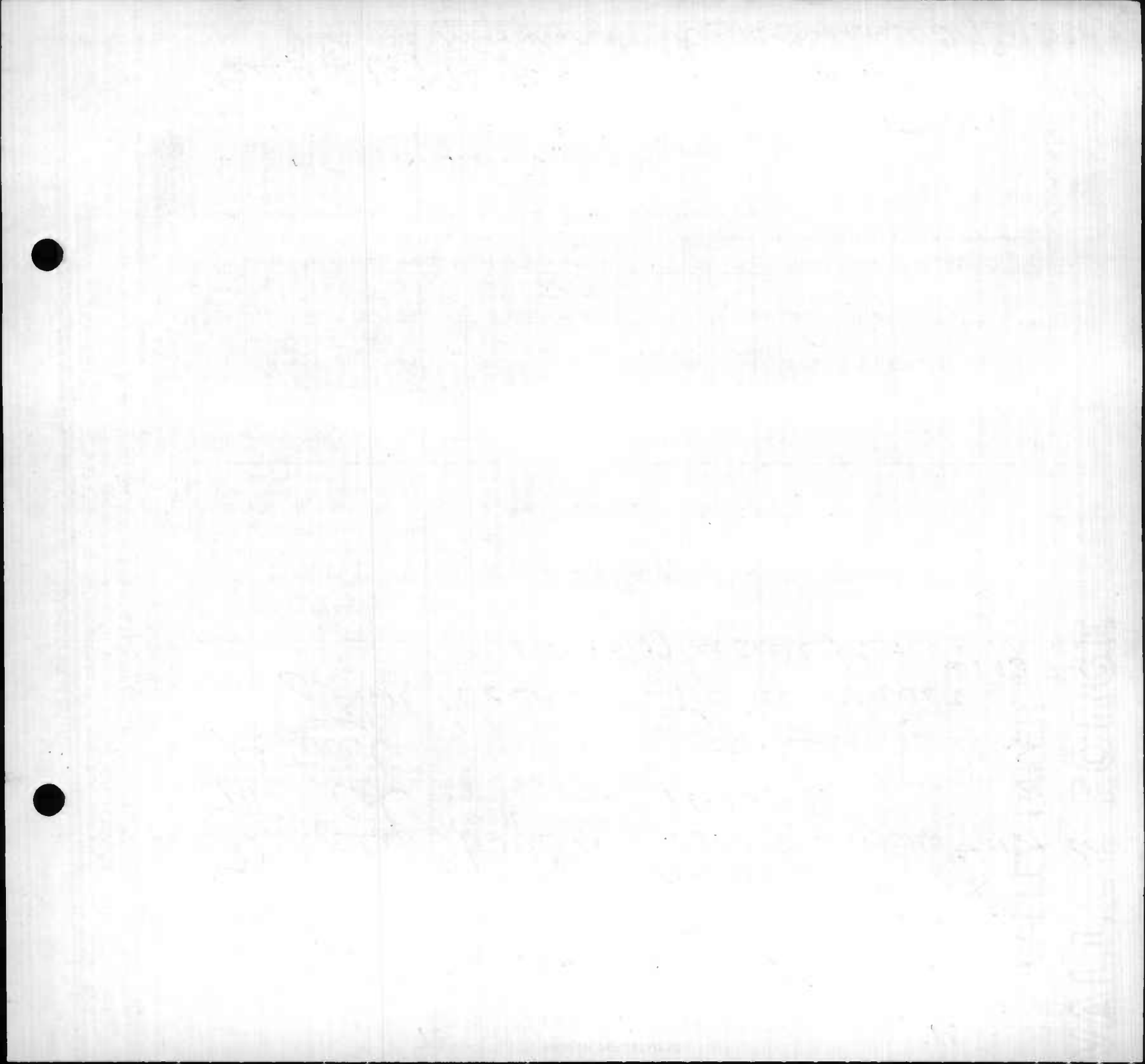
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 11645</u>
BIRTH NO. <u>72-17645 72 11645</u> CERTIFICATE OF DEATH				STATE OF MARYLAND-DEME
1. NAME OF DECEASED (Type or Print) <u>Kimberly Jacqueline Clark</u>		2. DATE AND HOUR OF DEATH <u>December 3 1972 1:15 P. M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED OR DECEASED <u>South Baltimore General Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>43 South Baltimore General Hospital</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX <u>Female</u> 6. RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/1/72</u> 9. AGE (in years last birthday) <u>43</u> 10. If Under 1 Yr. Months <u>1</u> Days <u>43</u> 11. If Under 24 Hrs. Hours <u>9</u> Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Frank D. Clark</u>		
14. MOTHER'S MAIDEN NAME <u>Nancy Irene Wolf</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mother</u> ADDRESS		
18. <u>486X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH <u>Massive Myocardial Infarction 43 hrs 9 min</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>Dec 1</u> 19 <u>72</u> to <u>Dec 3</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>Dec 3</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Terence A. Feltran</u>		23B. DATE SIGNED <u>Dec 3, 1972</u>		23C. PHYSICIAN'S NAME (Type) <u>Dr. Terence A. Feltran</u>
23D. ADDRESS <u>South Baltimore General Hospital</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		
24B. DATE <u>12/5/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem. Pk.</u>		24D. LOCATION (City, town, or county) (State) <u>Glen Burnie, MD.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 8 1972</u>		25B. NAME OF REGISTRAR <u>Andrew J. [Signature]</u>		25C. FUNERAL DIRECTOR <u>George L. [Signature]</u> ADDRESS <u>3101 Federal Ave</u>



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 11646	
72 11646 CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Lewie Kiser		12-3-72	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				Maryland 1547	
Mercy Hospital				C. CITY OR TOWN D. INSIDE CITY LIMITS? Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER				3113 Guilynns Fall pkwy	
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
m. Col				8. DATE OF BIRTH 10-19-1900	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (in years last birthday) 72 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
Retired				11. BIRTHPLACE (State or foreign country) S.C.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
John Kiser		Irene Kiser			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
		172-098727		Lucille Kiser 3113 Guilynns Fall pkwy	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute myocardial Infarction (B) Anteriosclerotic Heart disease (C) ...		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minutes	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 1 1972 to 12/3/72 19		that (I) (we) last saw the deceased alive on 12/3 19 72		and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE D. W. STEWART, M.D.				23B. DATE SIGNED 12/5/72	
23C. PHYSICIAN'S NAME (Type) D. W. STEWART, M.D.				23D. ADDRESS 2300 Garrison Blvd (21216)	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		12-7-72		Baltimore Em Balto	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
DEC 8 1972		Andrey ...		Rayner Sanders 217 E. Preston St	





44-12-10

72 11647

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

72 11647

STATE OF MARYLAND-DMH

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Wesolek, William W.

2. DATE AND HOUR OF DEATH

12/6/72

10 p. m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)31 Baltimore City Hospitals  
4940 Eastern Avenue  
Baltimore, Maryland 212244. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

924 S. Curley Street

5. SEX

Male

6. RACE

Caucasian

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

12/16/97

9. AGE (In years  
last birthday)

75

If Under 1 Yr.  
Months: Days:If Under 24 Hrs.  
Hours: Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

RETIRED LABOR

10B. KIND OF BUSINESS OR INDUSTRY

LARGES PACKING CO

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

FRANK WESOLEK

14. MOTHER'S MAIDEN NAME

CONSTANCE SZYMANSKA.

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

218-024906A

17. INFORMANT

4940 Eastern Avenue ADDRESS

BCH RECORDS: Baltimore, Maryland 21224

18. 4710.91

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B) hypoxia 2 to asthma

DUE TO, OR AS A CONSEQUENCE OF:

(C) possible myocardial infarction

ABCD

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY (Month) (Day) (Year) (Hour)  
(APPROX.)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from December 6 19 72 to  
that (I) (we) last saw the deceased alive on December 6 19 72 and that (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Marille C. S. Cole

Attending  
Phys. ☒Med.  
Director ☐Staff  
Phys. ☐

23B. DATE SIGNED

December 6, 1972

23C. PHYSICIAN'S  
NAME (Type)

Marille Cole MD

23D. ADDRESS

4940 Eastern Avenue

Baltimore, Md. 21224

24A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

24B. DATE

DEC 9 72

24C. NAME OF CEMETERY OR CREMATORY

HOLY CROSS CEMETERY

24D. LOCATION

GERMAN HILL RD BALTO MD

25A. DATE REC'D BY HEALTH DEPT

DEC 8 1972

25B. NAME OF REGISTRAR

Sidney [unclear]

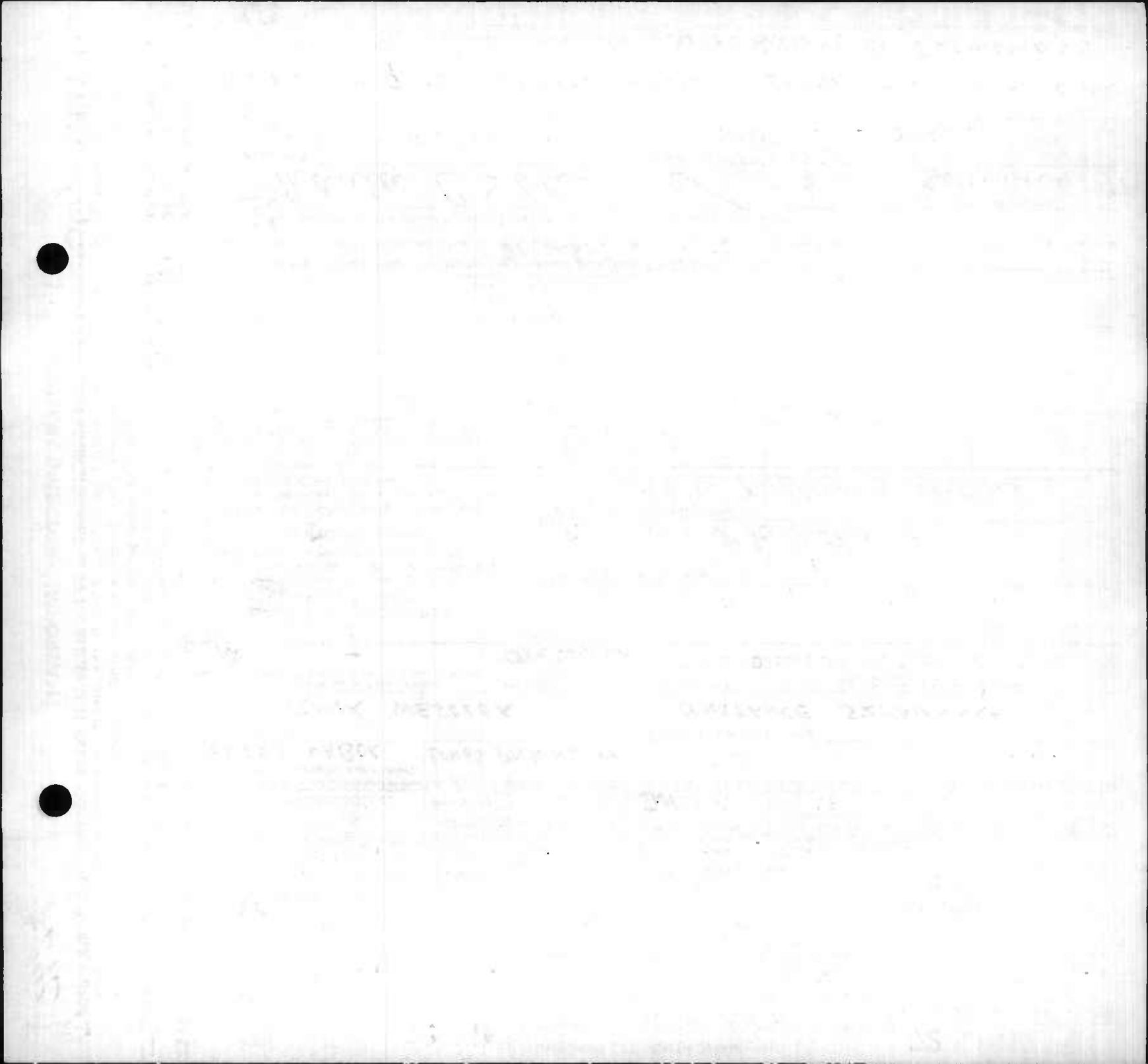
25C. FUNERAL DIRECTOR

DOPEL BROS INC 1800 E LOMBARD ST.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.





1  
11-460

72 11618

BALTIMORE CITY HEALTH DEPARTMENT

72 11618

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND-DEME

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) FLORENCE A. MILLER		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> December 6, 1972		M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 6300 Yorkshire Drive		3. DATE PRONOUNCED DEAD Month Day Year December 7, 1972		Hour 10:45 A.M.
6. SEX Female		7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 2-19-10		10. AGE (In years last birthday) 62	11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Jay Marsh		
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales		14B. KIND OF BUSINESS OR INDUSTRY Store Telephone-Dept.		
15. MOTHER'S MAIDEN NAME Ada Walker		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		
17. SOCIAL SECURITY NO. 212-46-6812		18. INFORMANT 1214 St. Francis Rd. William A. Miller, Jr. 21014		
19. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
20. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?		
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED December 7, 1972 ACTUAL SIGNATURE EXAMINER'S NAME (Type) Marvin S. Platt, M.D.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-11-72		24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery
24D. LOCATION (City, town, or county) (State) Parkville, Maryland		25A. DATE REC'D BY HEALTH DEPT. DEC 8 1972		
25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR Henry W. Jenkins Sons 4905 York Rd. Baltimore, Md. 21212		

PERG. 115

115

115

115

115

115

115

115

115

115

115

115

115

115

115

115

115

115

115

115

115

115

115

115

115

115

115

115

115

115

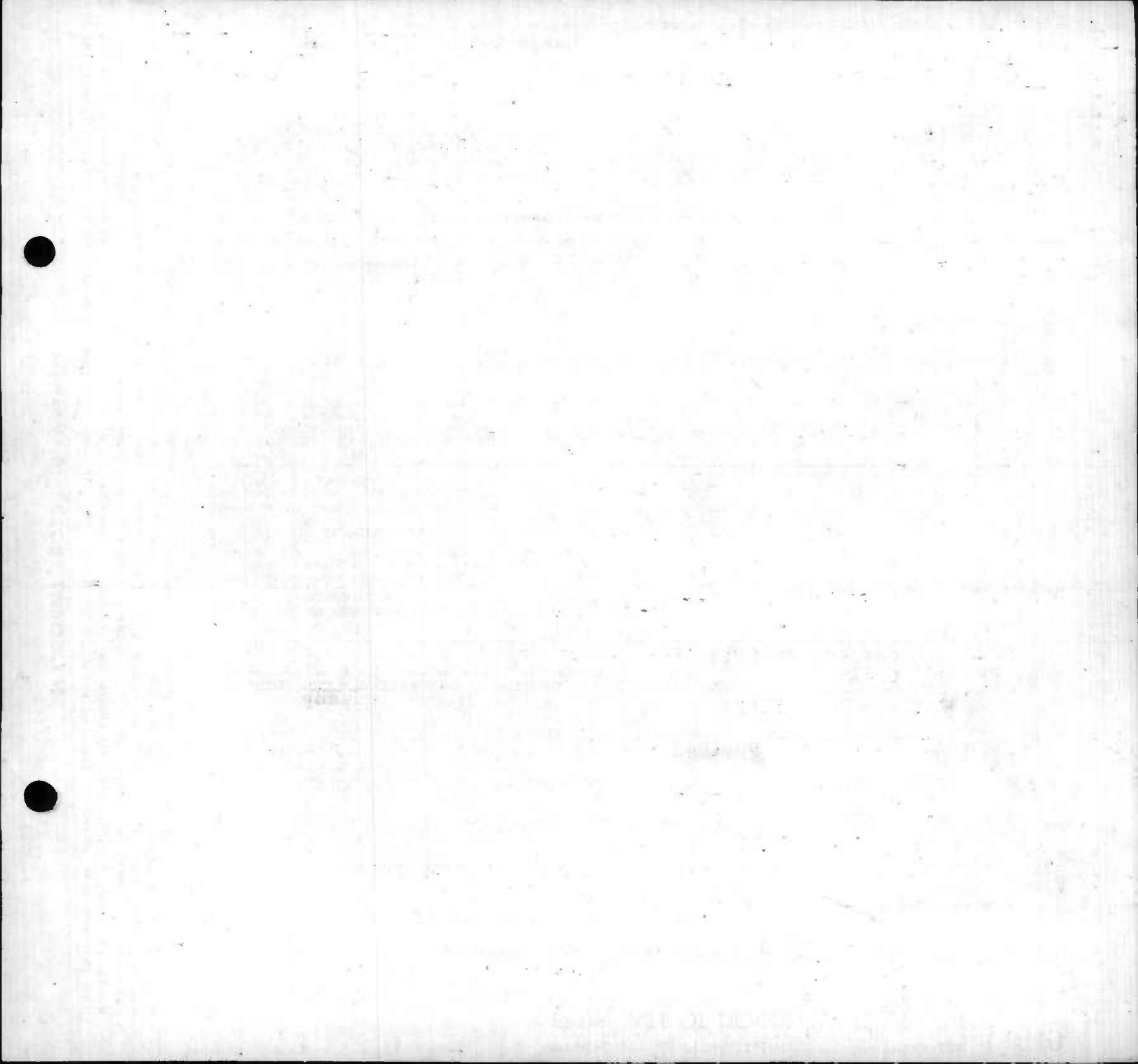
115

115

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 72 11649	
BIRTH NO. 72 11649				STATE OF MARYLAND-DEPT			
1. NAME OF DECEASED (Type or Print) <b>Jennie F. Bolger</b>				2. DATE AND HOUR OF DEATH <b>Dec-7-1972 8<sup>20</sup> A M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>90 Edgewood Nursing Home</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>BALTO</b> C. CITY OR TOWN <b>Towson</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>208 Willow Ave. 21204</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-31-82</b>		9. AGE (In years last birthday) <b>90</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Townley Shirt Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Ireland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph Bolger</b>				14. MOTHER'S MAIDEN NAME <b>Julia Fullam</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>215-07-6841</b>		17. INFORMANT <b>Mrs. Alberta Snedecor</b>		ADDRESS <b>1229 Providence Rd. 21204</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>412.4 x 188X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>Arteriosclerotic Cardio-Vascular Disease</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CHRONIC ARTERIOSCLEROSIS</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>- YEARS -</b>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>				(B) DUE TO, OR AS A CONSEQUENCE OF: <b>C.A. of Urinary Bladder -</b>		(C) <b>1412 -</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>0</b>				20A. AUTOPSY? (Yes or No) <b>no</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>12-4-1972</b> to <b>12-7-1972</b> , that (I) (we) last saw the deceased alive on <b>12-7-1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Anthony F. Carozza</b>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>12/7/72</b>	
23C. PHYSICIAN'S NAME (Last, first, middle) <b>Anthony F. CAROZZA</b>				23D. ADDRESS <b>5217 York Rd BALTO MD 21212</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-11-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 8 1972</b>		25B. NAME OF REGISTRAR <b>Sidney [Signature]</b>		25C. FUNERAL DIRECTOR <b>Henry W. Jenkins Sons</b>		ADDRESS <b>4905 York Rd. Baltimore, Md. 21212</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 11650		CERTIFICATE OF DEATH		REG. NO. 72 11650					
1. NAME OF DECEASED (Type or Print) <b>MIRIAM ELLEN ACKER</b>				2. DATE AND HOUR OF DEATH <b>December 7, 1972 5:30 P.M.</b>							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>90 Edgewood Nursing Home</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>906</b>							
5. SEX <b>Female</b> 6. RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>Nov. 21, 1894</b> 9. AGE (In years last birthday) <b>78</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>					
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Frank P Harper</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Ellen Megary</b>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>217-22-9103</b>		17. INFORMANT: Atty- <b>Robt. F. Podlich, 19 E. Fayette St., City</b> ADDRESS <b>21202</b>					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF:  (B) <b>Cardiac Disease</b> DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Dec 1 - Dec 7, 72</b>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from <b>Dec 7 1972</b> to <b>Dec 7 1972</b> , that (I) (we) lost saw the deceased olive on <b>Dec 6 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <b>George E. Shannon</b> DEGREE <b>MD</b>				23B. DATE SIGNED <b>Dec 7, 1972</b>							
23C. PHYSICIAN'S NAME (Type) <b>GEORGE E. SHANNON</b>				23D. ADDRESS <b>412 Medical Arts Building</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/8/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 8 1972</b>		25B. NAME OF REGISTRAR <b>Stewart &amp; Mowen</b>		25C. FUNERAL DIRECTOR ADDRESS <b>STEWART &amp; MOWEN CO. 108 W. North Av.</b>							

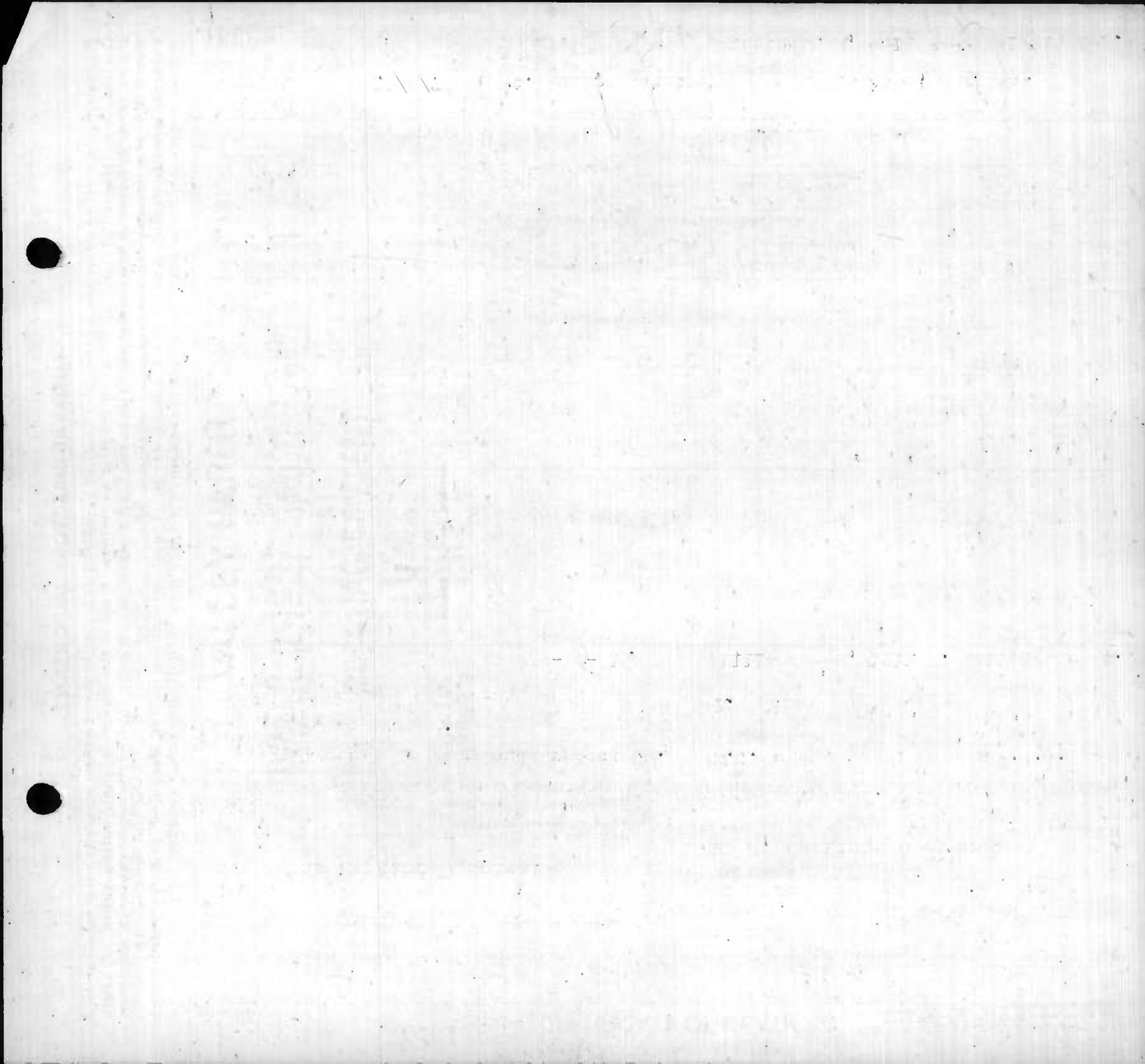




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-520		72 11651		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 11651	
BIRTH NO.				STATE OF MARYLAND-DEATH			
1. NAME OF DECEASED (Type or Print) <u>Jones Ben Frank</u>				2. DATE AND HOUR OF DEATH <u>12/1/72</u> <u>5</u> <u>9</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>The Johns Hopkins Hospital</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>802</u>			
5. SEX <u>Male</u>		6. RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/17/28</u>	
9. AGE (In years last birthday) <u>44</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		11. BIRTHPLACE (State or foreign country) <u>N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jack Jones</u>				14. MOTHER'S MAIDEN NAME <u>T. Jones</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>224-30-4166</u>		17. INFORMANT <u>Willie Jones, 1711 N. Collington St.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>? T B C</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Respiratory arrest</u> (B) <u>Lung Cancer</u> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>11/28/72</u> <u>1969 -</u>	
19A. DATE OF OPERATION <u>12/1/72</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>no</u>		20A. AUTOPSY? (Yes or No) <u>no</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>11/27</u> 19 <u>72</u> to <u>12/1</u> 19 <u>72</u> , that (I) (we) last saw the deceased alive on <u>12/1/72</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>David Curtis MD</u>						23B. DATE SIGNED <u>12/1/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Curtis, David L MD</u>						23D. ADDRESS <u>Johns Hopkins Hosp</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/5/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Auburn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 8 1972</u>		25B. NAME OF REGISTRAR <u>Audrey Anderson</u>		25C. FUNERAL DIRECTOR <u>6 Kenneth G</u>		ADDRESS <u>4611 Park Heights Ave.</u>	



G-615

72 11652

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 11652

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JOHN H. GRIFFIN

2. DATE  
OF  
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

00 4048 Park Heights Ave.

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

12

3

1972

8:05a

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

1513

6. SEX

male

7. RACE

negro

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

Feb. 4, 1908

10. AGE (In years  
last birthday)

64

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

4048 Park Heights Ave.

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Retired

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

Sadie Griffin, 2601 Shirley Ave.

19.

57181

CAUSE OF DEATH

Fatty metamorphosis of liver

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME  
OF INJURY  
(APPROX.)

(Month)

(Day)

(Year)

(Hour)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Ronald N. Kornblum, M.D. Deputy Chief Medical Examiner

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-4-72

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

12 7 72

24C. NAME OF CEMETERY or CREMATORY

Mt. Auburn Cemetery

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

DEC 8 1972

25B. NAME OF REGISTRAR

Sidney Johnston

25C. FUNERAL DIRECTOR

ADDRESS

Kenneth Law, 4611 Park Heights Ave.

J

J

200

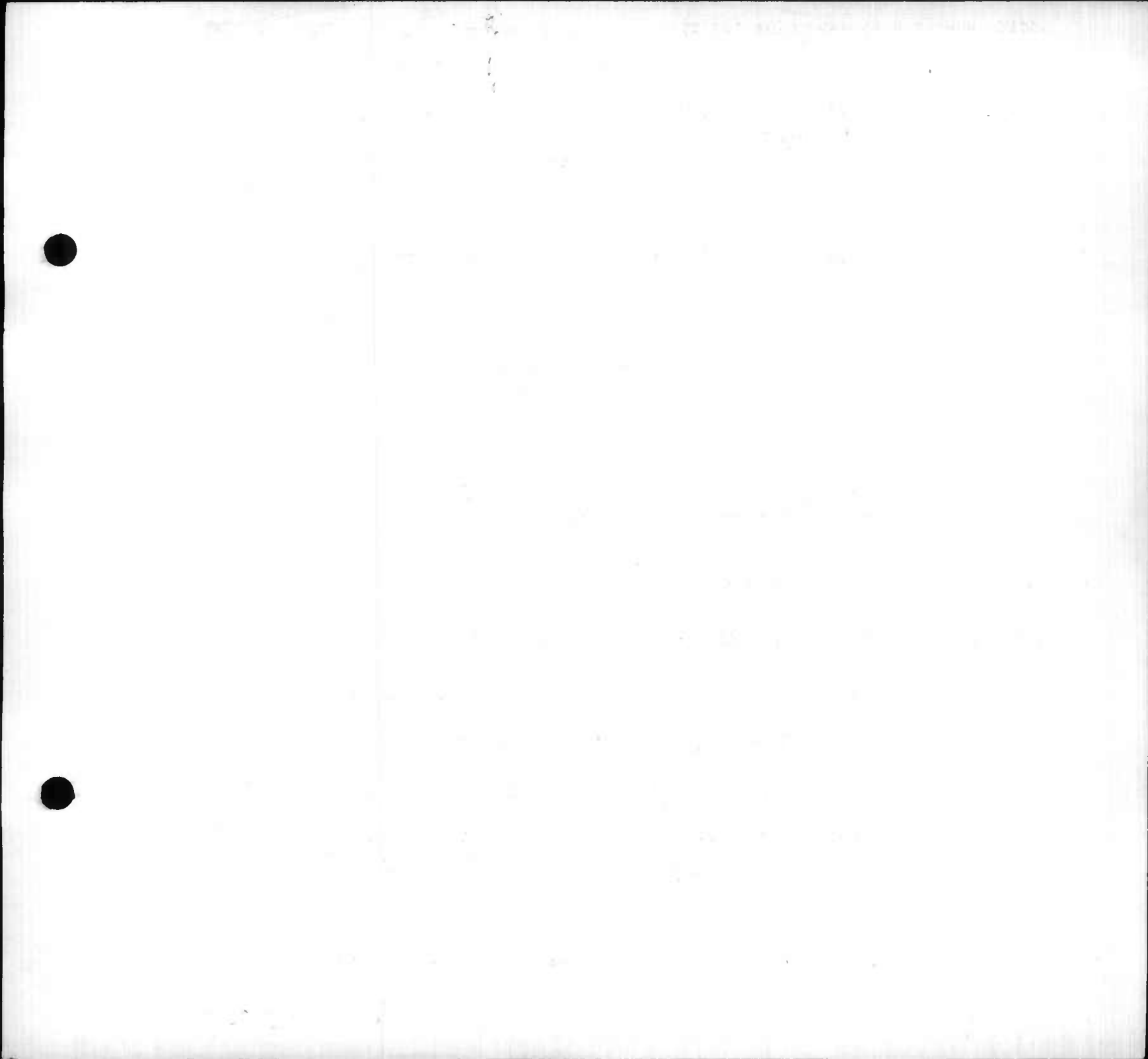
201

202

203

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 11653		REG. NO. 72 11653	
L-532				72 11653			
BIRTH NO.				72 11653			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
HARRY LINTHICUM				12-9-72 8:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE			
USPHS HOSPITAL				MARYLAND			
3100 WYMAN PARK DRIVE				C. CITY OR TOWN			
BALTIMORE, MARYLAND				BALTIMORE			
5. SEX				6. RACE			
MALE				WHITE			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>				8. DATE OF BIRTH			
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				JUNE 16, 1905			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				9. AGE (In years last birthday)			
LABORER				67			
10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)			
Vulcan Hart Co.				MARYLAND			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
JOHN LINTHICUM				MARY LUSBY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
No				214-22-7478			
17. INFORMANT				ADDRESS			
Mrs. Mary Hodges, 4703 Frederick Road				4703 Frederick Ave			
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				PNEUMONIA			
ANTECEDENT CAUSES				DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) BRONCHOGENIC CARCINOMA OF LUNG			
(C) _____				DUE TO, OR AS A CONSEQUENCE OF: WITH METASTASES			
II				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
MARCH 21, 1972				CARCINOMA OF LEFT LUNG			
20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
No				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour)			
21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?			
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				22. I certify that (I) (this hospital) attended the deceased from FEB. 2, 1972 to DEC. 9, 1972			
that (I) (we) last saw the deceased alive on DEC. 8, 1972 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				23A. SIGNATURE			
Harold E. Ramsey, M.D.				23B. DATE SIGNED			
HAROLD E. RAMSEY, M.D.				12-9-72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
HAROLD E. RAMSEY, M.D.				USPHS HOSPITAL			
24A. BURIAL CREMATION REMOVAL (Specify)				24B. DATE			
Burial				12/11/72			
24C. NAME OF CEMETERY OR CREMATORY				24D. LOCATION (City, town, or county) (State)			
Mount Olivet Cemetery				Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR			
DEC 8 1972				Witzke, 1630 Edmondson Avenue			
25C. FUNERAL DIRECTOR				ADDRESS			
Witzke, 1630 Edmondson Avenue				21228			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 11654	
BIRTH NO.				72 11654	
CERTIFICATE OF DEATH				REG. NO. 72 11654	
STATE OF MARYLAND, DEPT.					
1. NAME OF DECEASED (Type or Print) <b>SAMUEL Bryant</b>		2. DATE AND HOUR OF DEATH <b>12/7/72 10:20 P</b>		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>Maryland General Hosp</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2854</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Maryland General Hosp</b>		C. CITY OR TOWN <b>Balto</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>522 Old Orchard Road 21229</b>					
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/25/05</b>	9. AGE (In years lost birthday) <b>67</b>	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dentist</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>dentist self employed</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>Late F. Otis Bryant</b>		14. MOTHER'S MAIDEN NAME <b>Late Mary Elizabeth Holinger</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes WW 2</b>		16. SOCIAL SECURITY NO. <b>214-38-1575</b>		17. INFORMANT <b>Edna C. Bryant, 522 Old Orchard Road 21229</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Myocardial infarct</b> <b>Massive</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Arteriosclerotic C.V.D.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Recent &amp; Old</b> <b>40 yrs</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>2/2/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Dec 7, 19 22</b> to <b>Dec 7, 19 22</b> that (I) (we) last saw the deceased alive on <b>Dec 7, 19 22</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>William R. Davidson M.D.</b>		23B. DATE SIGNED <b>Dec 7, 19 22</b>			
23C. PHYSICIAN'S NAME (Type) <b>William R. Davidson M.D.</b>		23D. ADDRESS <b>Maryland General Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>		24B. DATE <b>12/11/72</b>		24C. NAME of CEMETERY or CREMATORY <b>Lorraine Park Mausoleum</b>	
24D. LOCATION <b>Baltimore, Maryland</b>		24E. (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 8 1972</b>		25B. NAME OF REGISTRAR <b>Witzke</b>		25C. FUNERAL DIRECTOR <b>630 Edmondson Avenue 21228</b>	



Mr. [unclear] 11.11.11

0

0

0

0

0

0

W M X

11/11/11

15/11/11

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 11655		72 11655	
D-560				72 11655		72 11655	
BIRTH NO.				72 11655		72 11655	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
Domer, Mr. Maurice, A.				Dec 10, 1972 1 8:35 AM		Bon Secours Hospital	
4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)				5. AGE (In years last birthday)		6. RACE	
A. STATE Maryland				69		White	
B. COUNTY				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
C. CITY OR TOWN Baltimore				WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11-19-3	
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				9. STREET AND NUMBER 624 Stamford Road		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Charles Henry Domer	
14. MOTHER'S MAIDEN NAME Mary Jane Smith				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-09-4110	
17. INFORMANT MRS. Ruth Domer 624 Stamford Rd				18. CAUSE OF DEATH 470.9.1		19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)	
20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hrs				21. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
23. MEDICAL CERTIFICATION				24. MEDICAL CERTIFICATION		25. MEDICAL CERTIFICATION	
26. MEDICAL CERTIFICATION				27. MEDICAL CERTIFICATION		28. MEDICAL CERTIFICATION	
29. MEDICAL CERTIFICATION				30. MEDICAL CERTIFICATION		31. MEDICAL CERTIFICATION	
32. MEDICAL CERTIFICATION				33. MEDICAL CERTIFICATION		34. MEDICAL CERTIFICATION	
35. MEDICAL CERTIFICATION				36. MEDICAL CERTIFICATION		37. MEDICAL CERTIFICATION	
38. MEDICAL CERTIFICATION				39. MEDICAL CERTIFICATION		40. MEDICAL CERTIFICATION	
41. MEDICAL CERTIFICATION				42. MEDICAL CERTIFICATION		43. MEDICAL CERTIFICATION	
44. MEDICAL CERTIFICATION				45. MEDICAL CERTIFICATION		46. MEDICAL CERTIFICATION	
47. MEDICAL CERTIFICATION				48. MEDICAL CERTIFICATION		49. MEDICAL CERTIFICATION	
50. MEDICAL CERTIFICATION				51. MEDICAL CERTIFICATION		52. MEDICAL CERTIFICATION	
53. MEDICAL CERTIFICATION				54. MEDICAL CERTIFICATION		55. MEDICAL CERTIFICATION	
56. MEDICAL CERTIFICATION				57. MEDICAL CERTIFICATION		58. MEDICAL CERTIFICATION	
59. MEDICAL CERTIFICATION				60. MEDICAL CERTIFICATION		61. MEDICAL CERTIFICATION	
62. MEDICAL CERTIFICATION				63. MEDICAL CERTIFICATION		64. MEDICAL CERTIFICATION	
65. MEDICAL CERTIFICATION				66. MEDICAL CERTIFICATION		67. MEDICAL CERTIFICATION	
68. MEDICAL CERTIFICATION				69. MEDICAL CERTIFICATION		70. MEDICAL CERTIFICATION	
71. MEDICAL CERTIFICATION				72. MEDICAL CERTIFICATION		73. MEDICAL CERTIFICATION	
74. MEDICAL CERTIFICATION				75. MEDICAL CERTIFICATION		76. MEDICAL CERTIFICATION	
77. MEDICAL CERTIFICATION				78. MEDICAL CERTIFICATION		79. MEDICAL CERTIFICATION	
80. MEDICAL CERTIFICATION				81. MEDICAL CERTIFICATION		82. MEDICAL CERTIFICATION	
83. MEDICAL CERTIFICATION				84. MEDICAL CERTIFICATION		85. MEDICAL CERTIFICATION	
86. MEDICAL CERTIFICATION				87. MEDICAL CERTIFICATION		88. MEDICAL CERTIFICATION	
89. MEDICAL CERTIFICATION				90. MEDICAL CERTIFICATION		91. MEDICAL CERTIFICATION	
92. MEDICAL CERTIFICATION				93. MEDICAL CERTIFICATION		94. MEDICAL CERTIFICATION	
95. MEDICAL CERTIFICATION				96. MEDICAL CERTIFICATION		97. MEDICAL CERTIFICATION	
98. MEDICAL CERTIFICATION				99. MEDICAL CERTIFICATION		100. MEDICAL CERTIFICATION	

1911-12-12

1911-12-12

1911-12-12

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

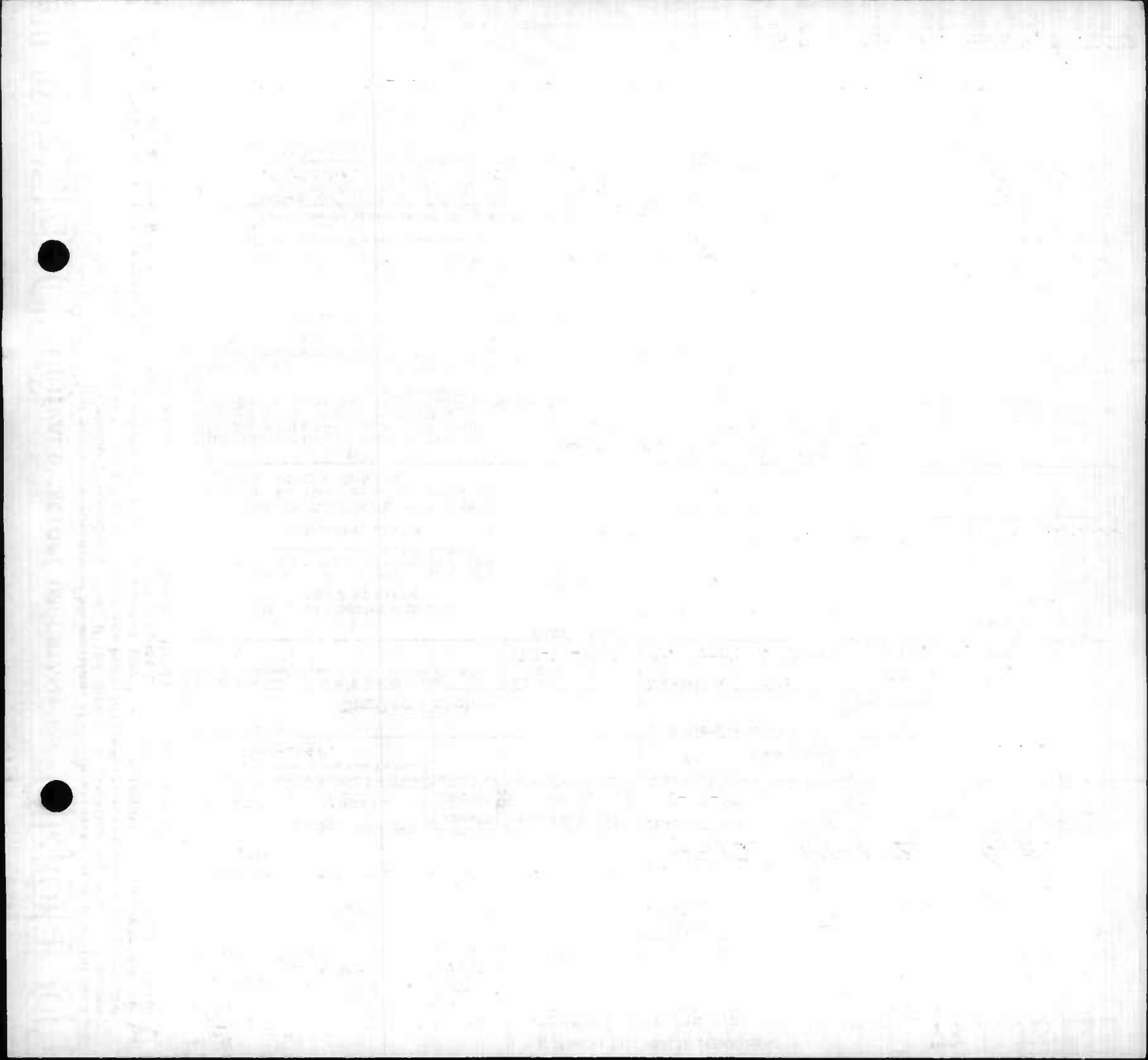
B-650		72 11656		BALTIMORE CITY HEALTH DEPARTMENT		72 11656	
BIRTH NO.		72 11656		REG. NO.		STATE OF MARYLAND - DEMO	
1. NAME OF DECEASED (Type or Print) <b>BROWN, MILDRED MARGARET</b>				2. DATE AND HOUR OF DEATH <b>DECEMBER 7, 1972 2:00P M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>40</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>ST. AGNES HOSPITAL CATON &amp; WILKENS AVES. BALTIMORE, MARYLAND 21229</b>		A. STATE <b>MARYLAND</b>		B. COUNTY <b>BALTIMORE</b>	
				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <b>5200 CARROLL PLACE</b>		<b>21227</b>	
5. SEX <b>FEMALE</b>	6. RACE <b>CAUCASIAN</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/19/07</b>	9. AGE (In years last birthday) <b>64</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RECEPTIONIST</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>PHYSICIAN OFFICE</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CLARENCE CARBACK</b>				14. MOTHER'S MAIDEN NAME <b>BLANCHE (HOUCK) CARBACK</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>214-01-2910</b>		17. INFORMANT <b>CATON &amp; WILKENS AVES. BALTO, MD 21229 ST. AGNES HOSPITAL RECORDS;</b>			
18. <b>41231</b> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cardiopulmonary arrest</b> <b>Presumably</b> <b>Coronary artery disease</b>							
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NONE</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>DECEMBER 04</b> 19 <b>72</b> to <b>DECEMBER 07</b> 1972, that (I) (we) last saw the deceased alive on <b>DECEMBER 07</b> 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>E Henzan</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>12/7/02</b>	
23C. PHYSICIAN'S NAME (Type) <b>E HENZAN</b>				23D. ADDRESS <b>BALTO, MD 21229 ST. AGNES HOSPITAL; CATON &amp; WILKENS AVE</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>12/9/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 8 1972</b>		25B. NAME OF REGISTRAR <b>Adrienne Watson</b>		25C. FUNERAL DIRECTOR <b>Ambrose J. Irac</b>		ADDRESS <b>1328 Sulphur Sp Rd</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>72 11657</b>	
A-650		72 11657	
BIRTH NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Anna R. Ahern</b>		2. DATE AND HOUR OF DEATH <b>12-2-77 10:05 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md</b> B. COUNTY <b>Balto</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>MARYLAND GENERAL HOSPITAL</b>		C. CITY OR TOWN <b>Edgemere</b>	D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <b>48</b>		E. STREET AND NUMBER <b>7312 BETZ AVE.</b>	
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-12-00</b>
9. AGE (in years last birthday) <b>72</b>		10. UNDER 1 Yr. Months Days	11. UNDER 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Ketchum</b>		14. MOTHER'S MAIDEN NAME <b>Rose Huhn</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) [If yes, give war or dates of service] <b>No</b>		16. SOCIAL SECURITY NO. <b>219-18-7267</b>	
17. INFORMANT Son: <b>Mr. Frank C. Ahern</b>		ADDRESS <b>7312 Betz Ave. Balto. Md. 21219</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Coronary Thrombosis</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Intermittent Coronary Artery Disease</b>	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Diabetic Mellitus</b>		<b>Pulmonary Embolism</b>	
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12/2/77</b> to <b>12/2/77</b> that (I) (we) last saw the deceased alive on <b>12/2/77</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Paul J. Duda</b>			23B. DATE SIGNED <b>12/3/77</b>
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS
DEGREE			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>12-7-72</b>	<b>Oak Lawn Cemetery</b>	<b>Baltimore, Maryland</b>
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 8 1972</b>		25B. NAME OF REGISTRAR <b>Sidney Johnston</b>	25C. FUNERAL DIRECTOR ADDRESS <b>John J. Duda 7922 Wise Ave. Dundalk, Md. 21222</b>





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-400		72 11658		BALTIMORE CITY HEALTH DEPARTMENT		72 11658		STATE OF MARYLAND-DEED	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
		BLAHA, HELEN MARIE		DECEMBER 06, 1972 3:20P M.				A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		MARYLAND		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
40 ST. AGNES HOSPITAL				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER		4611 CEDAR GARDEN RD 21229							
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?		
FEMALE	CAUCASIAN	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	03/22/97	75	Homemaker	DELEWARE	U.S.A.		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
MICHAEL CONNOLLY		ELEANOR Sullivan		No		218-14-5590		CATON & WILKENS AVES BALTO, MD 21229 ST. AGNES HOSPITAL RECORDS;	
18. 427.11		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:							
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		Pulmonary edema							
ANTECEDENT CAUSES		(B) Left ventricular failure							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)							
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
0				NO					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from NOVEMBER 15 1972 to DECEMBER 06 1972		that (I) (we) last saw the deceased alive on DECEMBER 06 1972		and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
K. Esna		12/6/72		K. ESNA		BALTO, MD 21229 ST. AGNES HOSPITAL; CATON & WILKENS AVES			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		12-9-1972		Parkwood Cemetery		Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
DEC 8 1972		Sidney H. Hubbard		Howard H. Hubbard		4107 Wilkens Ave. 21229			

DEPT. OF JUSTICE

21 VONE & MODERATE CALDER & HICKENS VINE  
JUL 10 1935

13/11/35

DECEMBER 10 1935

WOMEN 12 13 DECEMBER 19 1935

NO

10 11-1-27

RECEIVED DEPT. OF JUSTICE

21 VONE & MODERATE CALDER & HICKENS VINE  
JUL 10 1935

RECEIVED DEPT. OF JUSTICE

RECEIVED DEPT. OF JUSTICE

RECEIVED DEPT. OF JUSTICE

RECEIVED DEPT. OF JUSTICE

RECEIVED DEPT. OF JUSTICE

RECEIVED DEPT. OF JUSTICE

RECEIVED DEPT. OF JUSTICE

RECEIVED DEPT. OF JUSTICE

RECEIVED DEPT. OF JUSTICE

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>J-520</u> <u>72 11659</u>				CITY HEALTH DEPARTMENT		72 11659	
BIRTH NO. <u>67-35641</u>				CERTIFICATE OF DEATH		REG. NO. <u>STATE OF MARYLAND-DH</u>	
1. NAME OF DECEASED (Type or Print) <b>JOHN THOMAS JONES, IV</b>				2. DATE AND HOUR OF DEATH <b>12/04/72 10.35p M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>THE JOHNS HOPKINS HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>3916 CHESTERFIELD AVE. 1310 CHESAPEAKE STREET</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/20/67</b>	9. AGE (In years last birthday) <b>54</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CHILD</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>BALTO., Md</b>		
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>JOHN THOMAS JONES, III</b>				
14. MOTHER'S MAIDEN NAME <b>LINDA TROTMAN</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				
16. SOCIAL SECURITY NO. <b>—</b>			17. INFORMANT <b>Mrs. Linda J. Engel</b> ADDRESS <b>SAME</b>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <b>0</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from <b>May 1971</b> to <b>December 1972</b> , that (I) (we) last saw the deceased alive on <b>December 4 1972</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. 23A. SIGNATURE <b>Neil N. Senzer</b> 23B. DATE SIGNED <b>12/5/72</b> 23C. PHYSICIAN'S NAME (Type) <b>NEIL N. SENZER, M.D.</b> 23D. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b> 24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b> 24B. DATE <b>12-8-72</b> 24C. NAME OF CEMETERY OR CREMATORY <b>PARKWOOD CEMETERY</b> 24D. LOCATION (City, town, or county) (State) <b>BALTO., Md.</b> 25A. DATE REC'D BY HEALTH DEPT. <b>DEC 8 1972</b> 25B. NAME OF REGISTRAR <b>Audrey Johnston</b> 25C. FUNERAL DIRECTOR <b>J. Walter Corbin</b> ADDRESS <b>5444 BELAIR Rd.</b>							

THE UNIVERSITY OF CHICAGO  
LIBRARY

RECEIVED

THE UNIVERSITY OF CHICAGO

1900

1900

1900

THE UNIVERSITY OF CHICAGO  
LIBRARY

THE UNIVERSITY OF CHICAGO  
LIBRARY

THE UNIVERSITY OF CHICAGO  
LIBRARY

THE UNIVERSITY OF CHICAGO  
LIBRARY

THE UNIVERSITY OF CHICAGO  
LIBRARY

THE UNIVERSITY OF CHICAGO  
LIBRARY

THE UNIVERSITY OF CHICAGO  
LIBRARY

THE UNIVERSITY OF CHICAGO  
LIBRARY

THE UNIVERSITY OF CHICAGO  
LIBRARY

THE UNIVERSITY OF CHICAGO  
LIBRARY

THE UNIVERSITY OF CHICAGO  
LIBRARY

THE UNIVERSITY OF CHICAGO  
LIBRARY

THE UNIVERSITY OF CHICAGO  
LIBRARY

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Robert W. Bizon		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 12 Day 5 Year 72 Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Church Home and Hospital		3. DATE PRONOUNCED DEAD Month 12 Day 5 Year 72 Hour 12:55 p M.	
6. SEX male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission) A. STATE Md. B. COUNTY 201	
9. DATE OF BIRTH Feb. 17, 1948		10. AGE (In years lost birthday) 24	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph Bizon		14. STREET AND NUMBER 14 S. Chester St. #21231	
15. MOTHER'S MAIDEN NAME Catherine Korycki		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 218-46-9060		18. INFORMANT ADDRESS Mrs. Catherine Bizon - 14 S. Chester St.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Narcotic Addiction (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 12/9/72		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/6/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/9/72	
24C. NAME of CEMETERY or CREMATORY St. Stanislaus Cemetery		24D. LOCATION (City, town, or county) Baltimore, Maryland (State)	
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1972		25B. NAME OF REGISTRAR Sidney Johnston	
25C. FUNERAL DIRECTOR George A. Weber - 705 S. Ann St. #21231		ADDRESS	

1-11-1973 - Completion of cause of Death on a Pending Medical Examiner Death Certificate -  
Peter Lipkovic, M.D.      hs

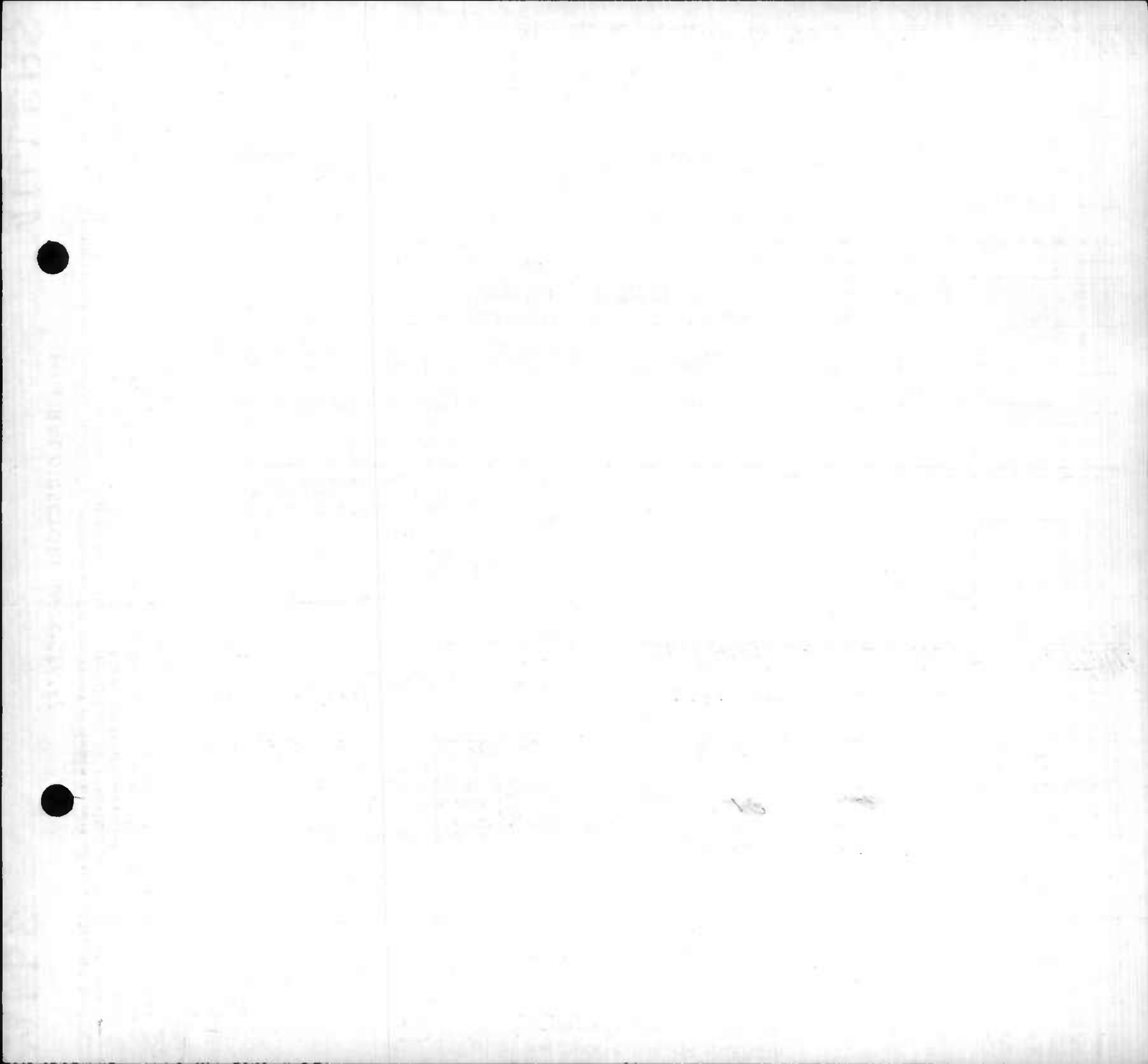


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

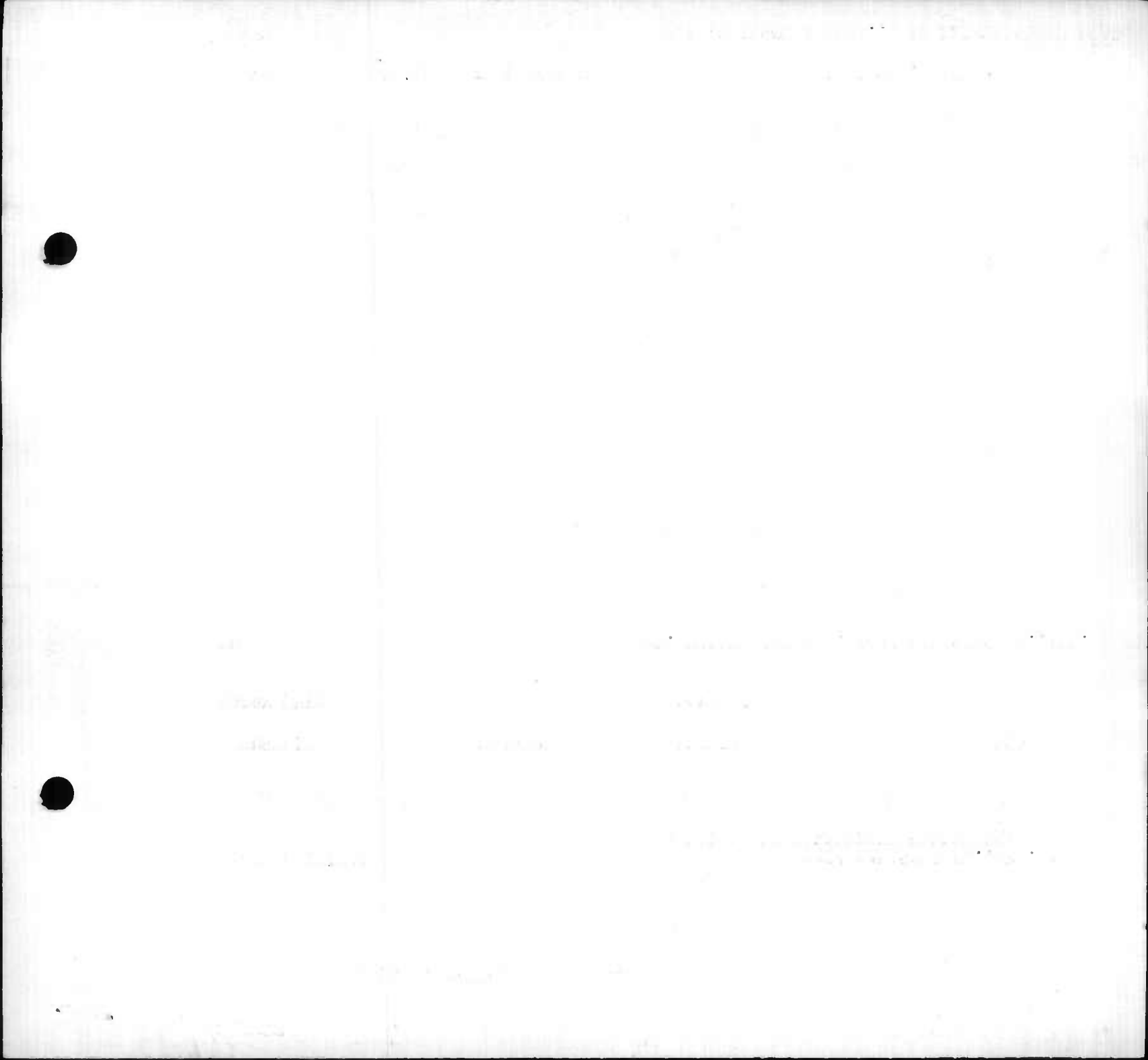
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 11661	
H-300 72 11661 CERTIFICATE OF DEATH				STATE OF MARYLAND, DEPT. OF HEALTH	
1. NAME OF DECEASED (Type or Print) <b>HOOD, Lois</b>		2. DATE AND HOUR OF DEATH <b>12/6/72 2:15 PM</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>1403</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>MARYLAND GENERAL HOSP.</b>		C. CITY OR TOWN <b>BALTO.</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>523 PRESSTMAN ST.</b>					
5. SEX <b>F</b>	6. RACE <b>N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-28-13</b>	9. AGE (In years last birthday) <b>59</b>	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>N.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>					
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Lois Hood-523 Presstman St. Balt., Md.</b>	
18. <b>73191</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Induracerebral Hemorrhage</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>massive</b>			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1 Month ( ) Day ( ) Year ( ) Hour ( )		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) lost saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Blair</b>		23B. DATE SIGNED <b>12/6/72</b>			
23C. PHYSICIAN'S NAME (Type) <b>Blair</b>		23D. ADDRESS <b>827 Linden Ave. Balt.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/11/72</b>		24C. NAME of CEMETERY or CREMATORY <b>Wt. Auburn</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 8 1972</b>		25B. NAME OF REGISTRAR <b>Lois Hood</b>		25C. FUNERAL DIRECTOR <b>Chapman Funeral Home - 1701 7th St. Balt., Md.</b>	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>BALTIMORE CITY HEALTH DEPARTMENT</b>  <b>CERTIFICATE OF DEATH</b></p>		<p>REG. NO. <b>72 11662</b>  <b>STATE OF MARYLAND-DEPT</b></p>	
<p><b>BIRTH NO.</b> <b>K-553</b></p>		<p><b>1. NAME OF DECEASED</b> (Type or Print) <b>XXXXXXXXXXXX ROSE KAMANITZ</b></p>	
<p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b></p> <p><b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>SINAI HOSPITAL</b></p>		<p><b>2. DATE AND HOUR OF DEATH</b>  <b>DECEMBER 7/72 7 15 P.M.</b></p>	
<p><b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission)  <b>A. STATE</b> <b>MARYLAND</b>  <b>B. COUNTY</b> <b>27 30</b></p>		<p><b>C. CITY OR TOWN</b> <b>BALTIMORE</b>  <b>D. INSIDE CITY LIMITS?</b> YES <input type="checkbox"/> NO <input type="checkbox"/></p>	
<p><b>5. SEX</b> <b>FEMALE</b>  <b>6. RACE</b> <b>WHITE</b>  <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/>  <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/></p>		<p><b>8. DATE OF BIRTH</b> <b>09/22/05</b>  <b>9. AGE</b> (In years last birthday) <b>67</b>  <b>If Under 1 Yr. Months Days</b> <b>If Under 24 Hrs. Hours Min.</b></p>	
<p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)  <b>HOUSEWIFE</b></p>		<p><b>10B. KIND OF BUSINESS OR INDUSTRY</b>  <b>AT HOME</b></p>	
<p><b>11. BIRTHPLACE</b> (State or foreign country)  <b>RUSSIA</b></p>		<p><b>12. CITIZEN OF WHAT COUNTRY?</b>  <b>USA</b></p>	
<p><b>13. FATHER'S NAME</b>  <b>HARRY WEIS</b></p>		<p><b>14. MOTHER'S MAIDEN NAME</b>  <b>DORA ?</b></p>	
<p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)  <b>NO</b></p>		<p><b>16. SOCIAL SECURITY NO.</b>  <b>17. INFORMANT</b> <b>MR. HARRY KAMANITZ, 2824 DAMASCUS CT., APT. B #9</b>  <b>ADDRESS</b></p>	
<p><b>18. CAUSE OF DEATH</b>  <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b>  <i>Acute Myocardial Infarction</i>  <b>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</b>  <b>ANTECEDENT CAUSES</b>  <i>Arteriosclerotic Heart Disease</i>  <b>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</b></p>		<p><b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b></p>	
<p><b>II</b>  <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b></p>			
<p><b>19A. DATE OF OPERATION</b>  <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b></p>		<p><b>20A. AUTOPSY?</b> (Yes or No) <b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b></p>	
<p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)  <b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)  <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p>		<p><b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)  <b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  <b>21F. HOW DID INJURY OCCUR?</b></p>	
<p><b>22. I certify that (I) (this hospital) attended the deceased from 12/7/72 to 12/7/72 that (I) (we) last saw the deceased alive on 12/7/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b></p>			
<p><b>23A. SIGNATURE</b>  <i>R. Pinto</i>  <b>23C. PHYSICIAN'S NAME</b> (Type) <b>R. PINTO</b></p>		<p><b>23B. DATE SIGNED</b>  <b>23D. ADDRESS</b> <b>SINAI HOSPITAL</b></p>	
<p><b>24A. BURIAL CREMATION, REMOVAL</b> (Specify)  <b>BURIAL</b></p>		<p><b>24B. DATE</b> <b>12/8/72</b>  <b>24C. NAME of CEMETERY or CREMATORY</b> <b>MKRO KODESH</b>  <b>24D. LOCATION</b> (City, town, or county) (State)  <b>BALTIMORE, MARYLAND</b></p>	
<p><b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>DEC 8 1972</b>  <b>25B. NAME OF REGISTRAR</b> <i>Sidney H. Koston</i>  <b>25C. FUNERAL DIRECTOR</b> <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>  <b>ADDRESS</b></p>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 11663		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. _____	
J-255 BIRTH NO. 72 11663		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>LEONARD JACHMAN</b>			2. DATE AND HOUR OF DEATH <b>DECEMBER 6, 1972</b> <b>5:30 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>3401 BANCROFT ROAD</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2740</b>		
5. SEX <b>MALE</b>			6. RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>DEC. 11, 1911</b>		9. AGE (In years last birthday) <b>60</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MFG.</b>	
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>JACOB JACHMAN</b>			14. MOTHER'S MAIDEN NAME <b>FLORENCE KELLNER</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service) <b>YES</b>		16. SOCIAL SECURITY NO. <b>W.W. II</b>		17. INFORMANT <b>MRS. ROSE JACHMAN, 3401 BANCROFT ROAD #21215</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>4/10-9 I</b> <b>CARDIO RESPIRATORY FAILURE</b> <b>ACUTE MYOCARDIAL INFARCTION</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Jan 5</b> 19 <b>46</b> to <b>Dec 6</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>Dec 6</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Willard Applefeld</i>				23B. DATE SIGNED <b>12/7/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>WILLARD APPLEFELD</b>		23D. ADDRESS <b>6615 REISTERSTOWN ROAD</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12/8/72</b>		24C. NAME of CEMETERY or CREMATORY <b>CHIZUK AMINO (ARLINGTON)</b>	
24D. LOCATION (City, town, or county) <b>BALTIMORE, MARYLAND</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 8 1972</b>			
25B. NAME OF REGISTRAR <i>Sidney Whitson</i>		25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>			

1950

1951

1952

1953

1954

1955

1956

1957

1958

1959

1960

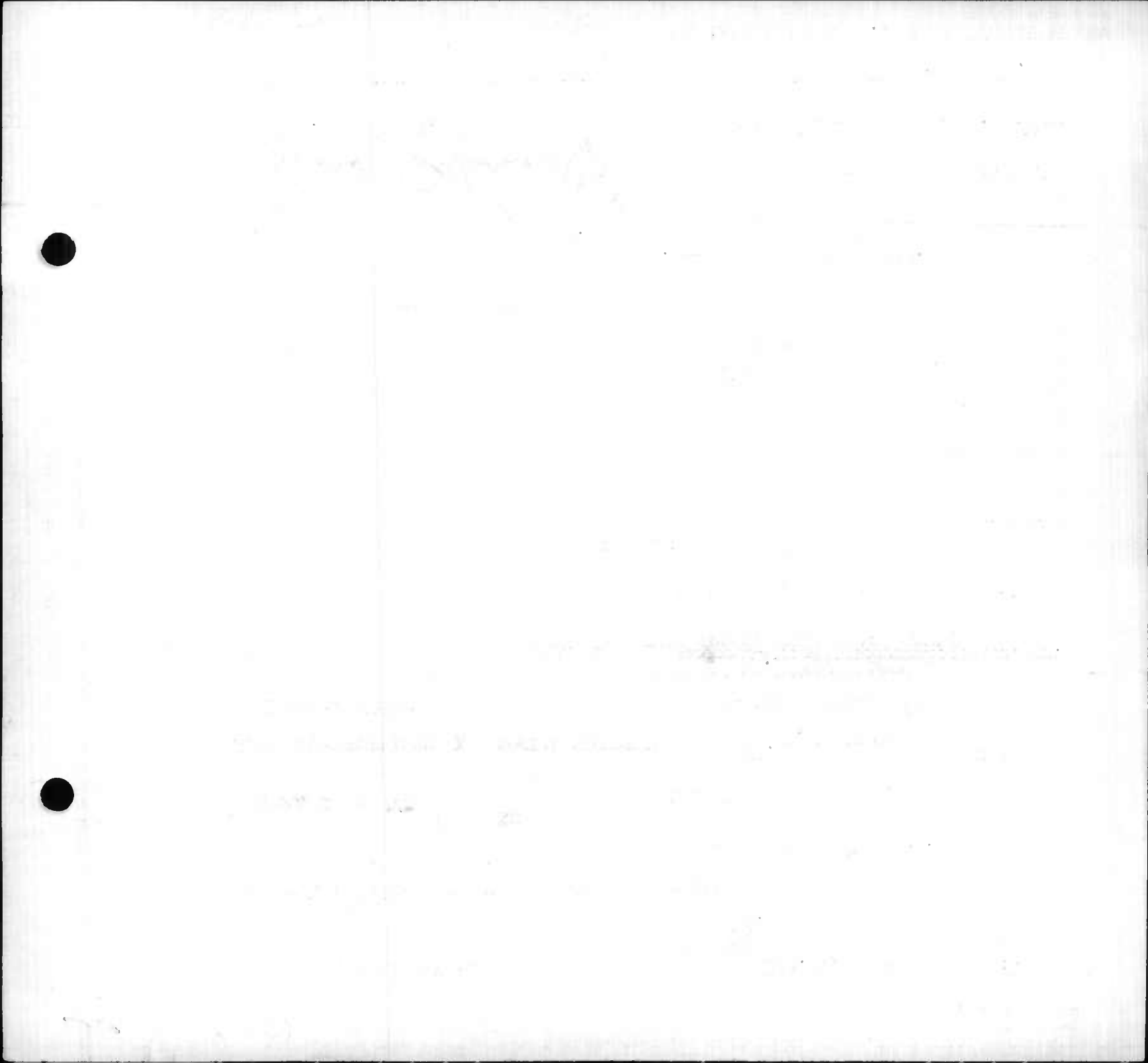
1961

1962

1963

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-420		72 11664		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 11664	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Hannah <del>XX</del> Block				2. DATE AND HOUR OF DEATH Dec. 7, 1972 4:20 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) US Public Health Service Hospital 2X 3100 Wyman Parkway				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY BALTO 5300			
5. SEX FEMALE 6. RACE Caucasian 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 2/16/20		9. AGE (In years last birthday) 52	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE SUPERVISOR				10B. KIND OF BUSINESS OR INDUSTRY SOCIAL SECURITY		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
13. FATHER'S NAME Isadore Miller				14. MOTHER'S MAIDEN NAME Elizabeth Hornstein			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 214-12-3721		17. INFORMANT MR. NORMAN BLOCK ADDRESS 2459 Forest Green Road #21209	
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 2 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Respiratory failure metastatic adenocarcinoma of lung		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden 1 year	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examined) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Nov. 11 1972 to Dec. 7 1972 that (I) (we) last saw the deceased alive on Dec. 7 1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Robert L. Belliveau, MD				23B. DATE SIGNED 12/7/72		23C. PHYSICIAN'S NAME (Type) Robert L. Belliveau, MD	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				24B. DATE 12/8/72		24C. NAME OF CEMETERY or CREMATORY OHEB SHALOM	
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1972				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. ADDRESS 6010 REISTERSTOWN ROAD	





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

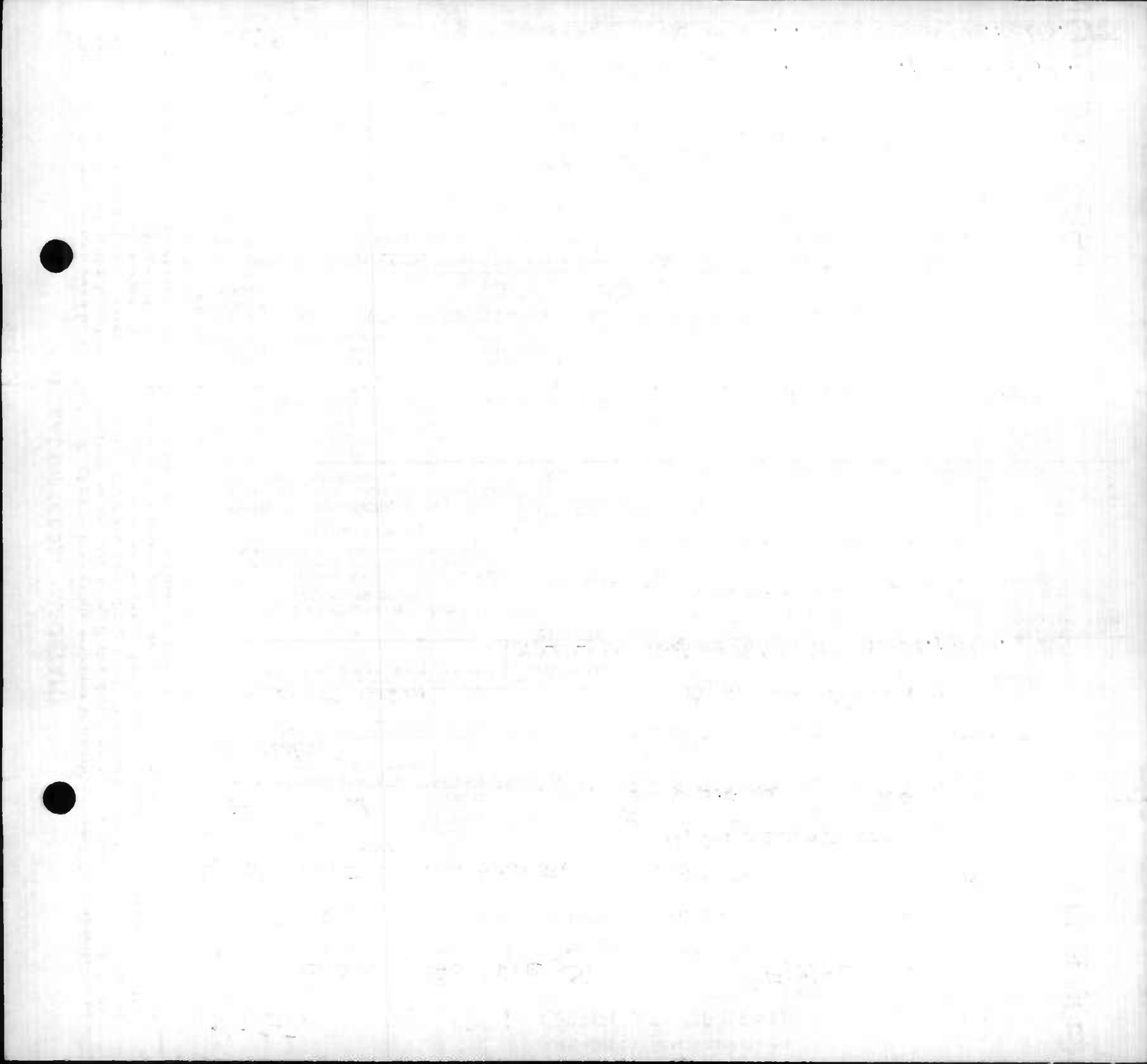
BALTIMORE CITY HEALTH DEPARTMENT				72 11665		72 11665	
CERTIFICATE OF DEATH				REG. NO.		72 11665	
1. NAME OF DECEASED (Type or Print) <b>FINK, IRENE XXX</b>				2. DATE AND HOUR OF DEATH <b>12-6-1972 3:57 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI HOSPITAL OF BALTIMORE</b> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION				4. USUAL RESIDENCE [Where deceased lived. If Institution: residence before admission] A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2906 SULGRAVE AVE. 21215</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-26-1907</b>		9. AGE (In years last birthday) <b>65</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>MORRIS KRONGARD</b>				14. MOTHER'S MAIDEN NAME <b>SARAH FORSCHLAGER</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) [If yes, give war or dates of service] <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>DR. ROBERT A. FINK, 20 FLORIDA AVE.</b> ADDRESS <b>BERKELEY, CALIF. 94707</b>			
18. <b>412.31</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <b>COMPLETE HEART BLOCK</b> DUE TO, OR AS A CONSEQUENCE OF: <b>ARTERIOSCLEROTIC HEART DISEASE</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>25 MINS.</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (H) (this hospital) attended the deceased from <b>12-5-1972</b> 19 to <b>12-6-1972</b> 19 that (H) (we) last saw the deceased alive on <b>12-6-1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Shobha Joshi</b>				23B. DATE SIGNED <b>12/6/1972</b>			
23C. PHYSICIAN'S NAME (Type) <b>SHOBHA JOSHI</b>				23D. ADDRESS <b>SINAI HOSPITAL OF BALTIMORE</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12/8/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>BETH EL MEMORIAL PARK</b>		24D. LOCATION (City, town, or county) (State) <b>RANDALLSTOWN, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 8 1972</b>		25B. NAME OF REGISTRAR <b>Andrew Johnston</b>		25C. FUNERAL DIRECTOR <b>SOE LEVINSON &amp; BROS.</b>		ADDRESS <b>6010 REISTERSTOWN ROAD</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

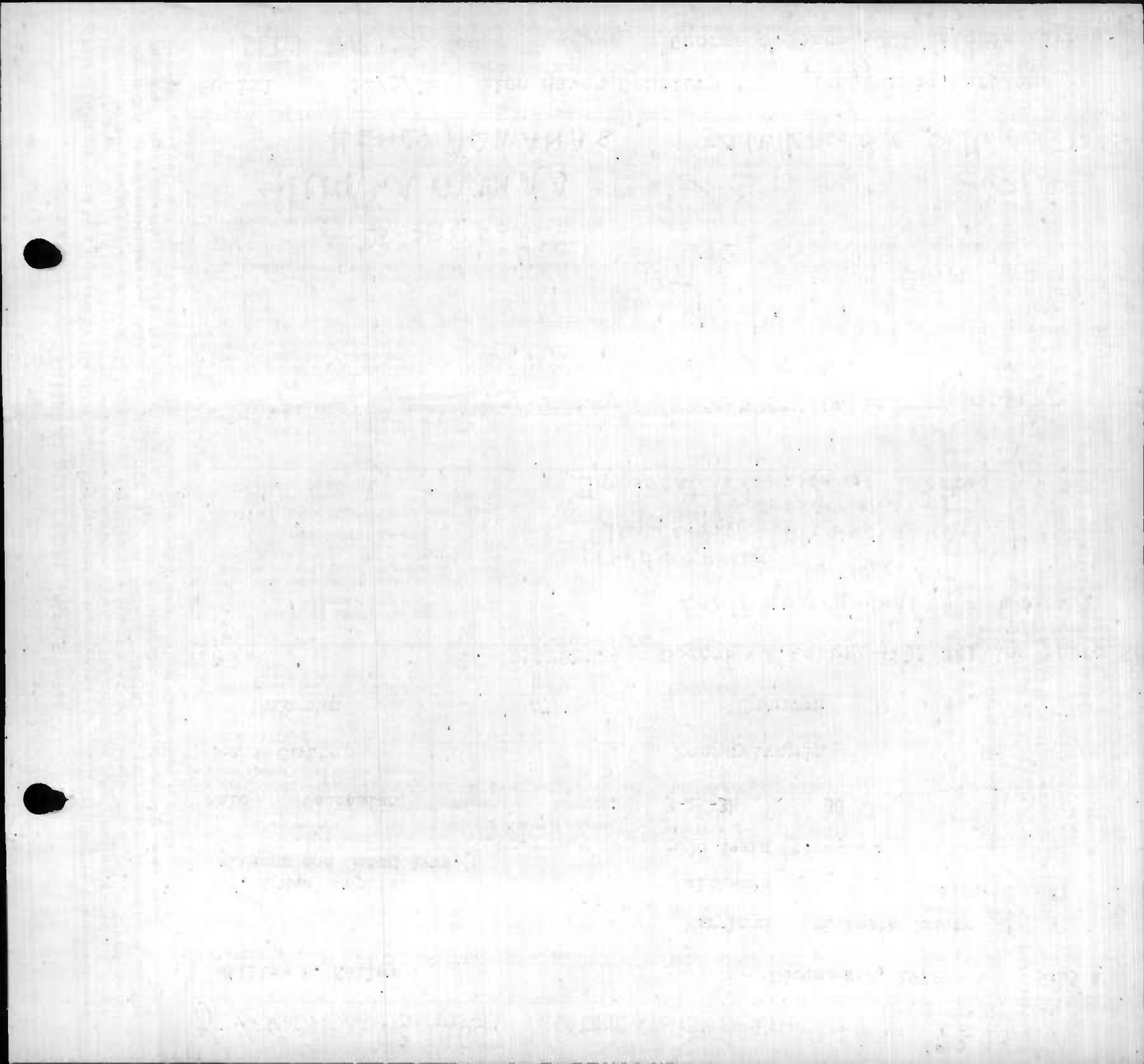
BALTIMORE CITY HEALTH DEPARTMENT											
CERTIFICATE OF DEATH											
BIRTH NO.		72 11666		REG. NO.		72 11666					
1. NAME OF DECEASED (Type or Print) <b>Gisin, Bonnie S.</b>				2. DATE AND HOUR OF DEATH <b>12/7/72 10-35</b>							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>AA</b>							
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>South Balto General Hospital</b>				C. CITY OR TOWN <b>BALTO</b>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX <b>F</b> 6. RACE <b>W</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>8/25/52</b>				9. AGE (in years last birthday) <b>20</b>		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Advertising</b>				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>ALBERT Gisin</b>				14. MOTHER'S MAIDEN NAME <b>Barbara Malkin (RUEHLING)</b>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>212-60-9329</b>		17. INFORMANT <b>Barbara Malkin 4109 2nd St., Balto. 21225</b>					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Extensive Brain damage</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Intracerebral Hemorrhage</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION <b>2</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>12-1-1972</b> to <b>12-7-1972</b> that (I) (we) lost saw the deceased alive on <b>12-7-1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <b>Seeni MD DEGREE</b>								23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) <b>SEENI MD DEGREE</b>				23D. ADDRESS <b>3001 S. Hanover St. South Balto General Hospital</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>12/11/72</b>		24C. NAME of CEMETERY or CREMATORY <b>Glen Haven Cemetery</b>				24D. LOCATION (City, town, or county) (State) <b>A. Arundel Co., Glen Burnie, Md. 21061</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 8 1972</b>				25B. NAME OF REGISTRAR <b>Friday Anderson</b>				25C. FUNERAL DIRECTOR <b>McCallister F. B. 237 Patapsco Ave., Balto. 21225</b>			



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 11667		72 11667	
K-400				72 11667		72 11667	
BIRTH NO.				72 11667		72 11667	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH		STATE OF MARYLAND - DEPT.	
William B. Kelley				December 2, 1972		5:45 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE Maryland		B. COUNTY Baltimore County	
St. Agnes Hospital Wilkins and Caton Aves.				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER 806 Regis Ct.			
5. SEX Male	6. RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-25-24	9. AGE (In years last birthday) 38	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meat Cutter			11. BIRTHPLACE (State or foreign country) Pennsylvania			12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 219288129		17. INFORMANT Dorothy M. Kelley 4131 Hollins Ferry Rd		
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE MYOCARDIAL FAILURE (cardiac arrest) failure				Hours			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. HYPERTENSIVE HEART DISEASE (open heart surgery)				years			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				weeks			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1971 to 1972 and that (I) (we) last saw the deceased alive on Dec 1 1972 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Henry Armanas				23B. DATE SIGNED Dec 2/72			
23C. PHYSICIAN'S NAME (Type) HENRY ARMANAS				23D. ADDRESS 1934 Wilkins Ave. Balt, Md 21223			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/5/72		24C. NAME OF CEMETERY or CREMATORY Glen Haven Cemetery		24D. LOCATION (City, town, or county) (State) Glen Burnie, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1972		25B. NAME OF REGISTRAR Adrian J. [Signature]		25C. FUNERAL DIRECTOR George J. Gonce		ADDRESS 4001 Ritchie Highway	



C-540

72 11668

BALTIMORE CITY HEALTH DEPARTMENT

72 11668

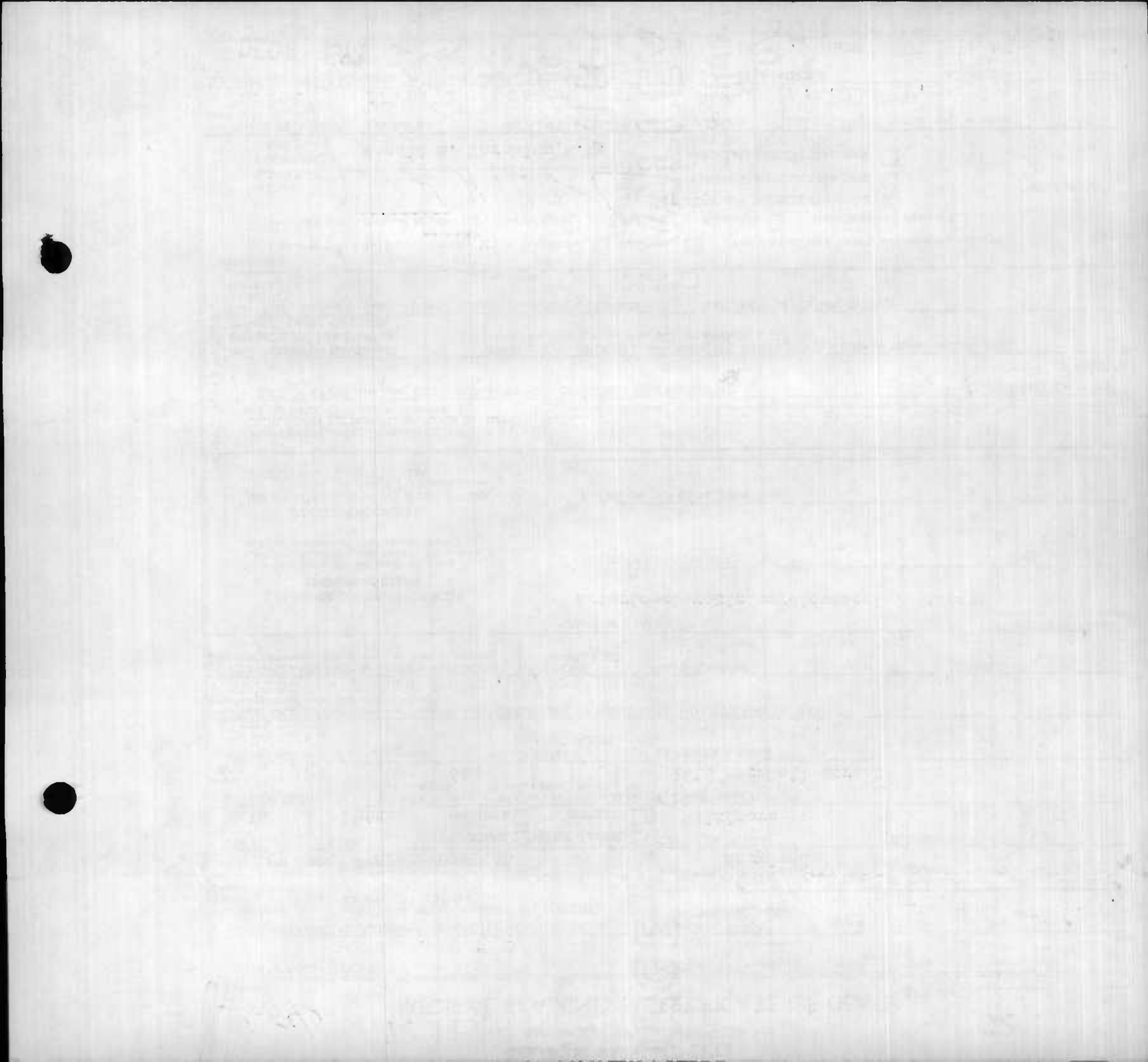
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JAMES P. CONLEY		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNION MEMORIAL HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour December 3, 1972 4:02 A.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 4/18/1904		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years last birthday) 68		E. STREET AND NUMBER 1426 Marshall Street	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME John Conley		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Warehouse Mgr. Hajoca Corp	
15. MOTHER'S MAIDEN NAME Unknown		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS Elizabeth Conley 1426 Marshall St.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no (inquiry)			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/3/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/6/72	
24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cemetery		24D. LOCATION (City, town, or county) (State) A.A. County, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1972		25B. NAME OF REGISTRAR Sidney H. [Signature]	
25C. FUNERAL DIRECTOR George J. Gonce		ADDRESS 4001 Ritchie Highway	

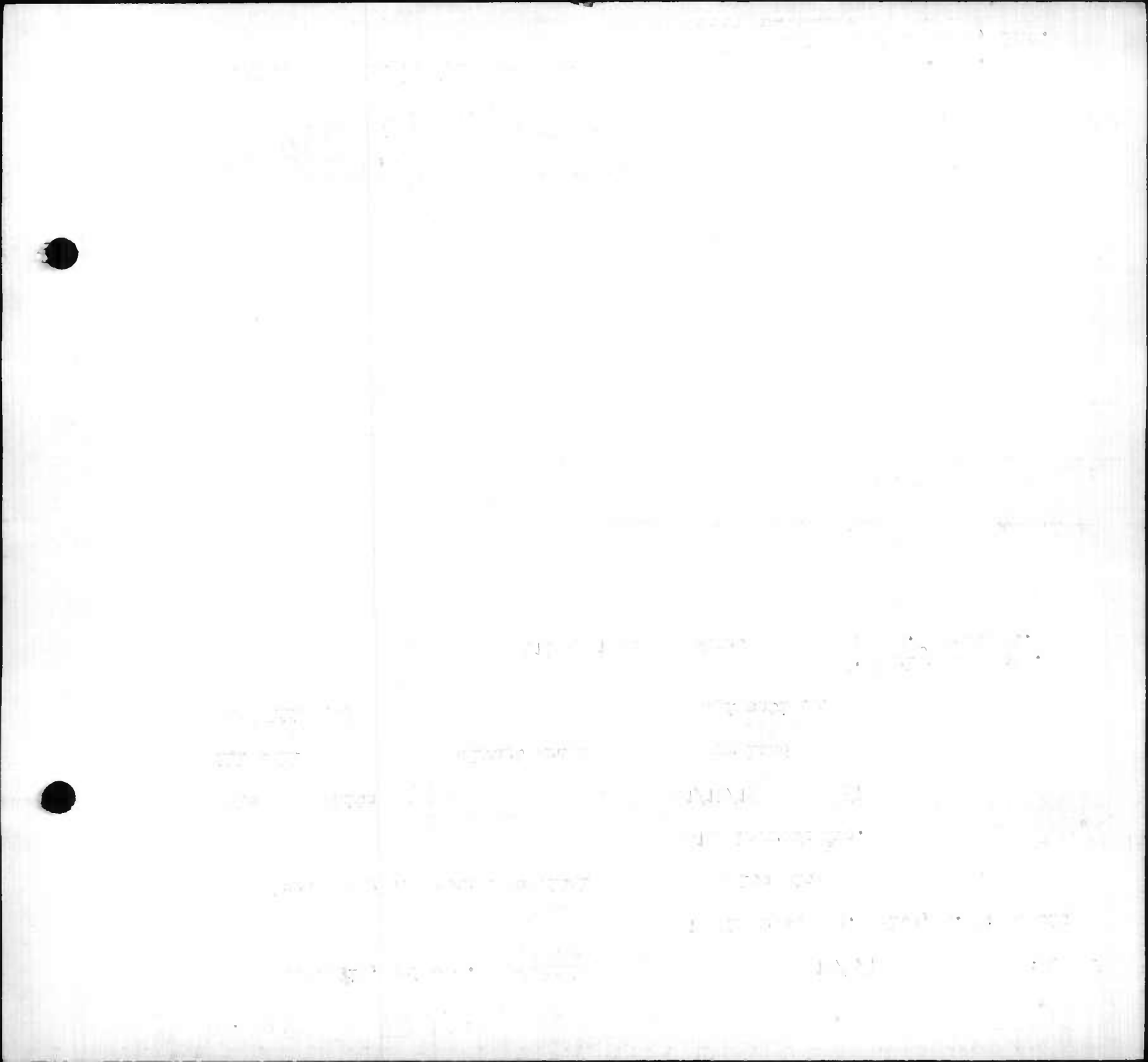




**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

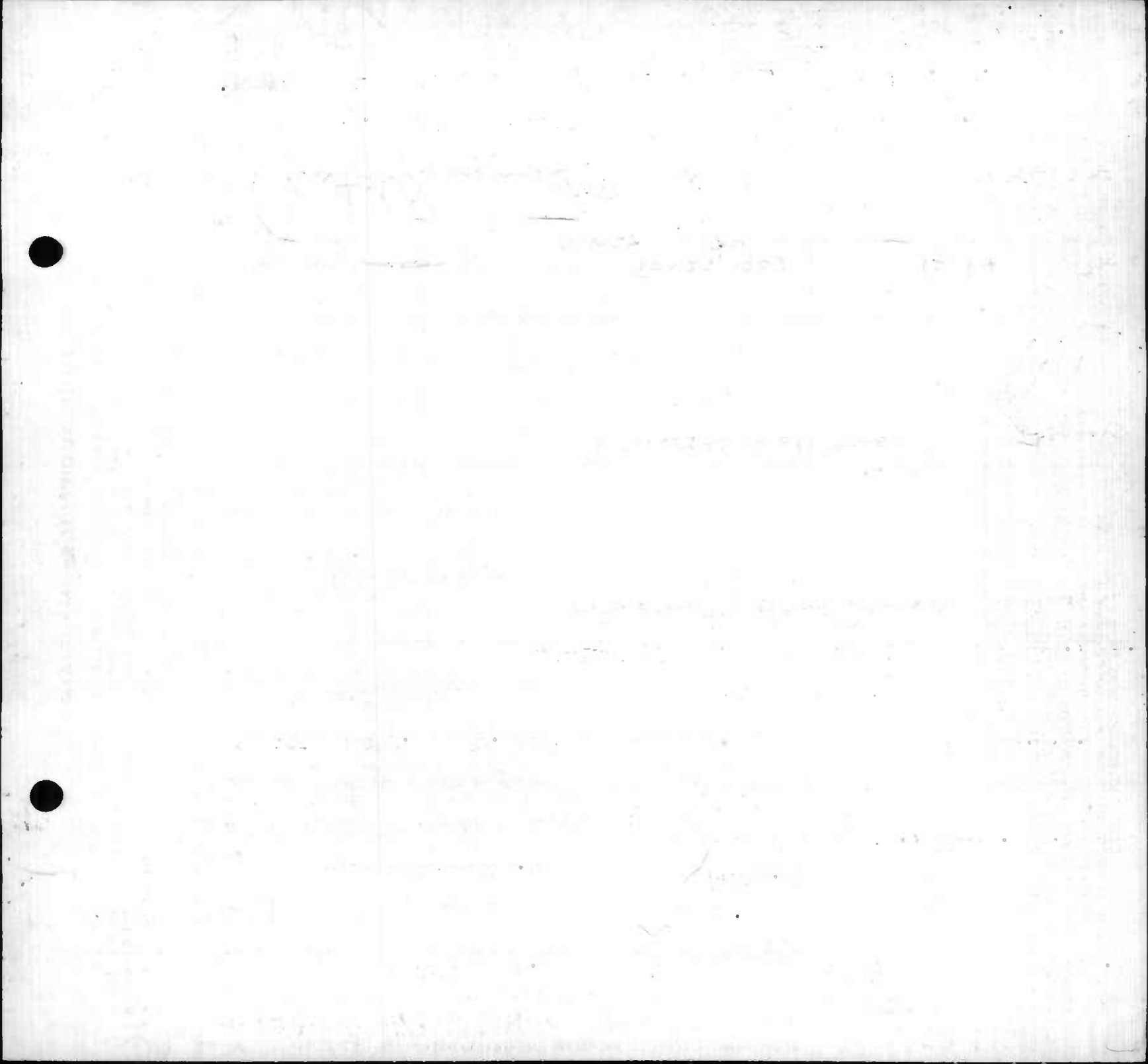
D-242		72 11669		BALTIMORE CITY HEALTH DEPARTMENT		72 11669	
CERTIFICATE OF DEATH				REG. NO.		STATE OF MARYLAND-DEWH	
1. NAME OF DECEASED (Type or Print) <b>DeJuliis, Perino A. DeJuliis</b>				2. DATE AND HOUR OF DEATH <b>12/6/72</b>   <b>6:50 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>North Charles General Hospital</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY <b>4616 Shamrock Ave. Balto, Md. 21206 city</b>			
				C. CITY OR TOWN <b>Balto City</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>4616 Shamrock Ave.</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>01/14/15</b>	9. AGE (In years last birthday) <b>57</b>	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Will call</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Calvert Drugs</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>DeJuliis (D)</b>				14. MOTHER'S MAIDEN NAME <b>Regimenti (D)</b>			
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>218 05 1426</b>		17. INFORMANT <b>Chart</b>		ADDRESS <b>N. Charles Gen Hosp. 2724 N. Charles St.</b>	
18. <b>531.91</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Pulmonary Edema - Cystic</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				(B) <b>Chronic Anemia</b> DUE TO, OR AS A CONSEQUENCE OF: <b>months</b>			
				(C) <b>Chronic Gastric ulcer</b> DUE TO, OR AS A CONSEQUENCE OF: <b>yes</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>ASHD</b>						<b>Yes</b>	
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Dec 1</b> 19 <b>72</b> to <b>Dec 6</b> 19 <b>72</b> and that (I) (we) last saw the deceased alive on <b>Dec 6</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Rupert Manankil M.D.</b>				23B. DATE SIGNED <b>12-7-72</b>		23C. PHYSICIAN'S NAME (Type) <b>MANANKIL RUPERT M.D.</b>	
23D. ADDRESS <b>North CHARLES GEN. Hosp. Md</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/11/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Moreland Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 8 1972</b>		25B. NAME OF REGISTRAR <b>A. J. [Signature]</b>		25C. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b>			
				ADDRESS <b>3331 Brehms Lane, Balto. Md. 21212</b>			



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 11670</u>	
H-220		72 11670		<b>CERTIFICATE OF DEATH</b>	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		CECILIA E. HUGHES		12/4/72 8:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  00 2850 Pelham Ave.				A. STATE Md.	
				B. COUNTY 831	
C. CITY OR TOWN Balto.				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 2850 Pelham Ave., Balto. Md. 21213	
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/28/08	9. AGE (In years last birthday) 64
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Medical Secty.		Dr. Farber		Md.	
13. FATHER'S NAME Michael Hughes				14. MOTHER'S MAIDEN NAME Mary Frances Ochs	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 218-18-0830	
				17. INFORMANT John Stathius (nephew)	
				ADDRESS Phila., Pa.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH Anteroseptic Heart Disease  (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				Diabetes Mellitus	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from Jan 23, 1963 to 12 14 1972, that (I) last saw the deceased alive on Nov 27 1972 and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (did not) view the body after death.					
23A. SIGNATURE Charles J. Singewald				23B. DATE SIGNED 12/6/72	
23C. PHYSICIAN'S NAME (Type) Dr. Martin Singewald				23D. ADDRESS 11 East Chase St.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/7/72		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery	
				24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1972		25B. NAME OF REGISTRAR Sidney B. Brehms		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.	
				ADDRESS 3331 Brehms Lane, Balto. Md. 21213	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 11671</u>
<u>1-525</u> <b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <u>JOHNSON, John Thomas</u>		<b>2. DATE AND HOUR OF DEATH</b> <u>December 6, 1972</u> <u>10:00</u> <u>A</u> M.		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Veterans Administration Hospital</u> <u>3900 Loch Raven Blvd.</u> <u>Baltimore, Maryland 21218</u>		<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Anne Arundel</u> <b>C. CITY OR TOWN</b> <u>Arnold</u> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <u>Rt 1 Box 12</u> <u>RT#5</u> <u>Box 200</u>		
<b>5. SEX</b> <u>Male</u>	<b>6. RACE</b> <u>White</u>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input checked="" type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>7/15/89</u>	
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <u>Unknown</u>		<b>9. AGE</b> (In years last birthday) <u>83</u>
<b>11. BIRTHPLACE</b> (State or foreign country) <u>Virginia</u>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>John B. Johnson</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Frances</u>	
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>7/25/17 to 9/3/19</u>		<b>16. SOCIAL SECURITY NO.</b> <u>223-18-1457</u>		<b>17. INFORMANT</b> <u>Records</u> <b>ADDRESS</b> <u>VAH, 3900 Loch Raven Blvd., Balto., Md.</u>
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Acute Respiratory failure</u> <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>COPD, Pneumonia</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. _____ <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). _____			<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <u>1/2 hour</u>	
<b>19A. DATE OF OPERATION</b> <u>2</u>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> _____		<b>20A. AUTOPSY?</b> (Yes or No) <u>Yes</u>
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location) <u>YES</u>
<b>21D. TIME OF INJURY</b> (APPROX.) (Month) (Day) (Year) (Hour) _____		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b> _____
<b>22. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>October 26,</u> 19 <u>72</u> to <u>December 6,</u> 19 <u>72</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>December 6,</u> 19 <u>72</u> and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (not) view the body after death.				
<b>23A. SIGNATURE</b> <u>Donald E. Klug</u>			<b>23B. DATE SIGNED</b> <u>12/6/72</u>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <u>Donald E. Klug</u> <u>M.D.</u>			<b>23D. ADDRESS</b> <u>3900 Loch Raven Blvd. Balto., Md.</u>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>24B. DATE</b> <u>Dec 9, 1972</u>		<b>24C. NAME OF CEMETERY OR CREMATORY</b> <u>Meadowridge Cemetery</u>
<b>24D. LOCATION</b> (City, town, or county) (State) <u>Dorsey</u> <u>AA.</u> <u>Md.</u>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>DEC 8 1972</u>		
<b>25B. NAME OF REGISTRAR</b> <u>Audrey Johnson</u>		<b>25C. FUNERAL DIRECTOR</b> <u>Bartanco Funeral Home</u>		

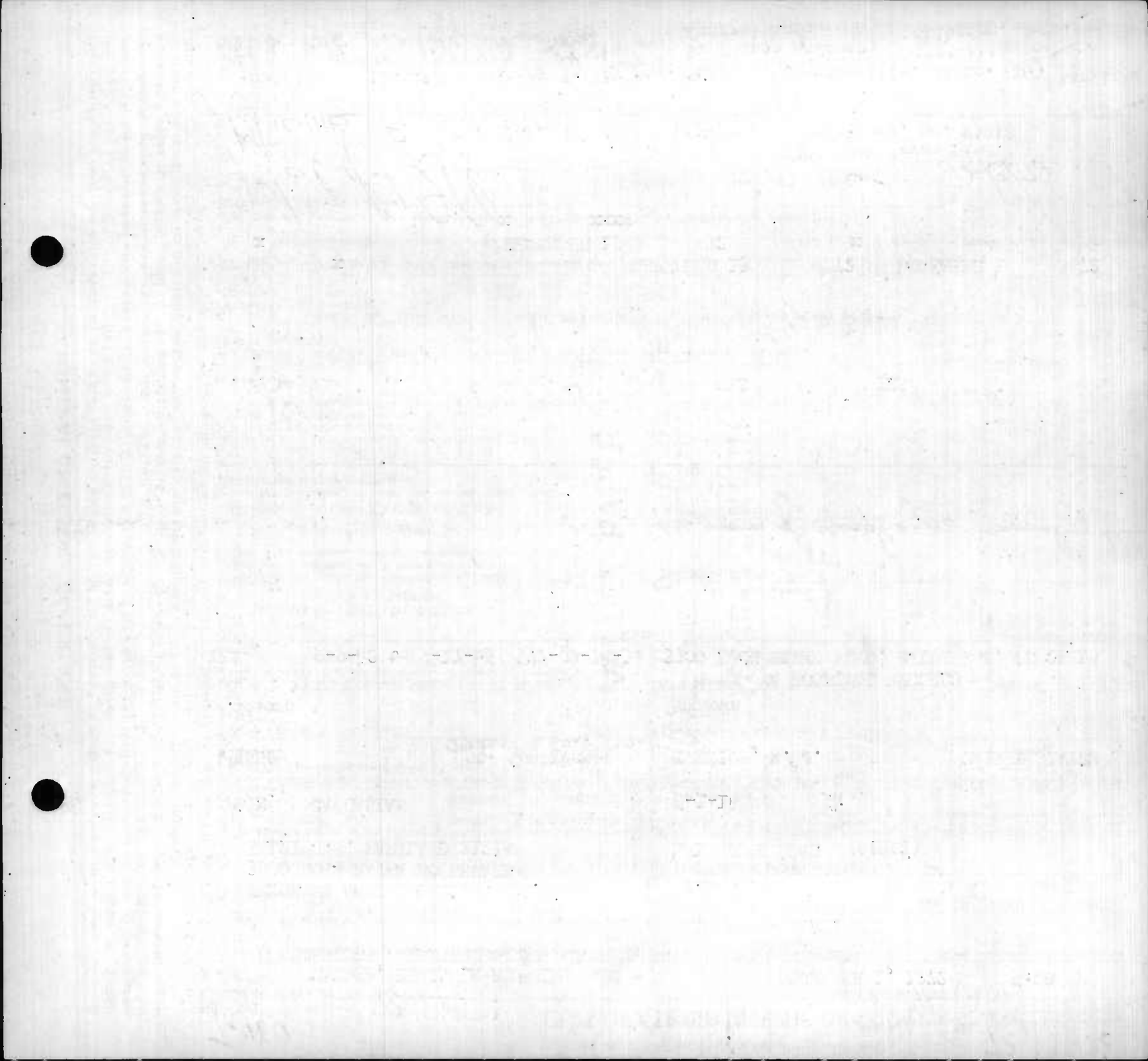
10-11-1940  
12-11-40



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="float: right;">72 11672</span>				CITY HEALTH DEPARTMENT		REG. NO. <span style="float: right;">72 11672</span>	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH		STATE OF MARYLAND - <del>DEME</del>	
TAYLOR, BENJAMIN ROBERT (Mike)				DECEMBER 1, 1972		5:20 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED OEO				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
VETERANS ADMINISTRATION HOSPITAL				MARYLAND BALTIMORE			
3900 LOCH RAVEN BOULEVARD				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
BALTIMORE, MARYLAND 21218				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER				4610 YORK ROAD (21212)			
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
MALE		CAUCASIAN		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5-1-18	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
WEDDER		Gen. Contractor Chasney & Co., Inc.		TRENTON, N. J.		UNITED STATES	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Unknown				Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT VA HOSPITAL RECORDS ADDRESS	
YES 9-9-42 to 9-17-45				579-09-78-36		3900 LOCH RAVEN BLVD, BALTIMORE, MD 21218	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				Resp arrest			
ANTECEDENT CAUSES				(B) Met. carcinoma of esophagus several months			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
3/11/22/72		mobility to eat		YES		YES	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>NOVEMBER 13</u> 19 <u>72</u> to <u>DECEMBER 1</u> 19 <u>72</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>DECEMBER 1</u> 19 <u>72</u> and that in <u>(we)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <u>(not)</u> view the body after death.							
26A. SIGNATURE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
MICHAEL F. GRAHAM MD.				V.A.H.		12/3/72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
MICHAEL F. GRAHAM MD.				3900 Loch Raven Blvd. Baltimore, Md. 21218			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		12-5-72		Dulaney Valley Mem. Gdns.		Cockeysville, Balto. Co., Maryland	
25A. DATE REC'D BY HEALTH OFF.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
DEC 8 1972		Sidney Johnston		F. Eugene McComas		1321 Abingdon Rd. Abingdon, Maryland	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 72 11673	
K-152 72 11673				STATE OF MARYLAND - DEPT. OF HEALTH	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
RUBIN KIPNIS			DECEMBER 6/72 9 <sup>30</sup> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
00 5726 GREENSPRING AVE			MARYLAND 2755		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			5726 GREENSPRING AVE		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
MALE	WHITE		OCT 21, 1901	71	SELF EMPLOYED
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
SELF EMPLOYED			REAL ESTATE		POLAND
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
SCHLMO KIPNIS			GITTEL		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
NO					ANNE KIPNIS - 5726 GREENSPRING AVE
18. CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			?		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			CEREBRAL THROMBOSIS		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) SEVERE ATHEROSCLEROSIS YEARS		
			(C) MULTIPLE CORONARY THROMBOSES		
II			HYPERTENSION (PACEMAKER IMPLANT) 1970		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/4 1979 to 12/6 1972, that (I) (we) lost saw the deceased alive on 12/3 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE		23B. DATE SIGNED	
E.T. LISANSKY		12/6/72			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
E.T. LISANSKY		6804 PK. HTS. AVE (2125) BALTO M.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		DEC 7/72		CHIZUK AMUNO	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
DEC 8 1972		Aristy Winston		SOL LEVINSON 200 6010 REISTERSTOWN ROAD	

THE UNIVERSITY OF CHICAGO  
LIBRARY

1950  
JAN 10 1950

1950  
JAN 10 1950

1950  
JAN 10 1950

1950  
JAN 10 1950

1950  
JAN 10 1950

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 11674		REG. NO. 72 11674	
<b>B-620</b> <b>72 11674</b> <b>CERTIFICATE OF DEATH</b>		<b>1</b> <b>DATE OF DEATH</b> <b>12/5/72</b>		<b>5:45 P.M.</b> <b>TIME</b>		<b>STATE OF MARYLAND</b>	
<b>1. NAME OF DECEASED</b> <b>(Type or Print)</b> <b>BERKOW, JOSEPH. I.</b>		<b>2. DATE AND HOUR OF DEATH</b> <b>12/5/72</b>		<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b> <b>51 MAY HOSPITAL OF BALTIMORE</b> <b>42</b>		<b>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</b> <b>A. STATE</b> <b>MARYLAND</b> <b>B. COUNTY</b> <b>BALTIMORE</b>	
<b>5. SEX</b> <b>MALE</b>		<b>6. RACE</b> <b>WHITE</b>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>1/26/22</b>	
<b>9. AGE (In years last birthday)</b> <b>50</b>		<b>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <b>NONE</b>		<b>11. BIRTHPLACE (State or foreign country)</b> <b>BALTIMORE, MD.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>BENJAMIN. BERKOW</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>XXXXXXXXX LEE ROSENTHAL</b>		<b>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</b> <b>NO</b>		<b>16. SOCIAL SECURITY NO.</b> <b>NO</b>	
<b>17. INFORMANT</b> <b>MR. BENJAMIN BERKOW, 6503 PARK HEIGHTS AVE.</b>		<b>18. CAUSE OF DEATH</b> <b>427.21</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> <b>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</b> <b>Acute Renal Failure</b> <b>72 hrs</b>		<b>19. ANTECEDENT CAUSES</b> <b>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</b> <b>(A) IMMEDIATE CAUSE</b> <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <b>Cardio Respiratory Arrest</b> <b>7 days</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>Acute Respiratory Failure</b> <b>7 days</b>		<b>20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b> <b>Little's Disease, Severe Kyphoscoliosis</b> <b>49 yrs</b>	
<b>21A. DATE OF OPERATION</b> <b>0</b>		<b>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</b> <b>NO</b>		<b>21C. WHERE DID INJURY OCCUR?</b> <b>(If in Baltimore City, give exact location)</b>		<b>21D. TIME OF INJURY (APPROX.)</b> <b>(Month) (Day) (Year) (Hour)</b>	
<b>21E. INJURY OCCURRED</b> <b>While At Work</b> <input type="checkbox"/> <b>Not While At Work</b> <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>		<b>22. I certify that (I) (this hospital) attended the deceased from</b> <b>11/29/1972</b> <b>to</b> <b>12/5/1972</b> <b>that (I) (we) last saw the deceased alive on</b> <b>12/5/1972</b> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>		<b>23A. SIGNATURE</b> <b>Alihas, M.D.</b> <b>DEGREE</b>	
<b>23B. DATE SIGNED</b> <b>12/5/72</b>		<b>23C. PHYSICIAN'S NAME (Type)</b> <b>A. MIHAS, MD</b> <b>DEGREE</b>		<b>23D. ADDRESS</b> <b>51 MAY HOSPITAL OF BALTIMORE</b>		<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>	
<b>24B. DATE</b> <b>12/7/72</b>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <b>CHIZUK AMUNO (ARLINGTON)</b>		<b>24D. LOCATION (City, town, or county) (State)</b> <b>BALTIMORE, MARYLAND</b>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>DEC 8 1972</b>	
<b>25B. NAME OF REGISTRAR</b> <b>Sidney Berkow</b>		<b>25C. FUNERAL DIRECTOR</b> <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN RD.</b>		<b>25D. ADDRESS</b>		<b>VS 150-REV. 1/1/68</b>	

2115/48 - Adm.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 11675	
P-450 72 11675				STATE OF MARYLAND - DDMH	
BIRTH NO. PLAIN E ESTELLE				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) ESTELLE PLAIN E				2. DATE AND HOUR OF DEATH 12/6/72 11 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY Maryland BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) CHURCH HOME and Hospital				C. CITY OR TOWN B. CITY INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 40	
5. CHURCH HOME and Hospital				E. STREET AND NUMBER 8E PLEASANT ST CHARLES TOWERS	
5. SEX FEMALE		6. RACE WHITE		8. DATE OF BIRTH 9-28-1930	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) 42 yrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRIVATE DUTY NURSE				11. BIRTHPLACE (State or foreign country) Maryland	
10B. KIND OF BUSINESS OR INDUSTRY HOSPITAL				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM PLAIN E				14. MOTHER'S MAIDEN NAME DORIS FELDMAN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE				16. SOCIAL SECURITY NO. 212-28-7413	
17. INFORMANT MR. WILLIAM PLAIN E, 1035 NORMAN APT. T6				ADDRESS ANNAPOLIS, MD. 21403	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CARDIO RESPIRATORY FAILURE				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 1/2 hr and 30 minutes	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cancer breast with secondary in Lungs & Pneumonia	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(B) DUE TO, OR AS A CONSEQUENCE OF:	
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/5/72 to 12/6/1972 that (I) (we) last saw the deceased alive on 12/6/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE G. Guruswamy				23B. DATE SIGNED 12/6/72	
23C. PHYSICIAN'S NAME (Type) GOPAC GURUSWAMY, M.D.				23D. ADDRESS CHURCH HOME and Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/7/72		24C. NAME OF CEMETERY or CREMATORY BETH TFILOH	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. DEC 8 1972			
25B. NAME OF REGISTRAR Sidney Whitman		25C. FUNERAL DIRECTOR SQL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			



12-26-1972 - Affidavit of Father and Birth Certificate of Deceased - Born September 28, 1930  
Baltimore, Maryland - Certificate #D-72654. ~~1111~~

HS

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>R-251</b>				72 11676				BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH				REC. NO. <b>72 11676</b>			
1. NAME OF DECEASED (Type or Print) <b>Mayme Roseberg</b>								2. DATE AND HOUR OF DEATH <b>12-4-72 C 7:35 P M.</b>											
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>Mercy Hospital</b>								4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>BALTO MD</b> B. COUNTY <b>BALTO</b> C. CITY OR TOWN <b>BALTO</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>6202 Gist Ave 2720</b>											
5. SEX <b>FEMALE</b>		6. RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-27-94</b>		9. AGE (In years last birthday) <b>78</b>		If Under 1 Yr. Months: Days: Hours: Min.		11. BIRTHPLACE (State or foreign country) <b>BALTO MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>								10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>											
13. FATHER'S NAME <b>LOUIS SNEIDMAN</b>								14. MOTHER'S MAIDEN NAME <b>Rebecca ?</b>											
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>212-32-10</b>				17. INFORMANT <b>MRS. SUNYA SMITH, 6202 GIST AVE. #21215</b>											
18. <b>4/10/91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. If means the disease, injury or complication which caused death.) <b>Acute myocardial infarction</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 hours</b>											
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>atherosclerotic heart disease</b>								(B) DUE TO, OR AS A CONSEQUENCE OF: <b>7 yrs.</b>											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Congestive heart failure</b>																			
19A. DATE OF OPERATION <b>0</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)											
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?											
22. I certify that (I) (this hospital) attended the deceased from <b>12-4-72</b> to <b>12-4-72</b> , that (I) (we) last saw the deceased alive on <b>12-4-72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																			
23A. SIGNATURE <b>G. VANEGAS, MD</b>								23B. DATE SIGNED <b>12-4-72</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>							
23C. PHYSICIAN'S NAME (Type) <b>G. VANEGAS, MD</b>								23D. ADDRESS <b>MERCY HOSPITAL</b>											
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>				24B. DATE <b>12/6/72</b>				24C. NAME OF CEMETERY or CREMATORY <b>HEBREW FRIENDSHIP</b>				24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>							
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 8 1972</b>				25B. NAME OF REGISTRAR <b>Sidney Whitton</b>				25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS.</b>				ADDRESS <b>6010 REISTERSTOWN ROAD</b>							

UNITED STATES DEPARTMENT OF THE ARMY  
OFFICE OF THE ADJUTANT GENERAL  
WASHINGTON, D. C.

TO: THE ADJUTANT GENERAL  
FROM: THE ADJUTANT GENERAL  
SUBJECT: [Illegible]

[Illegible text block]

DATE: [Illegible]

BY: [Illegible]

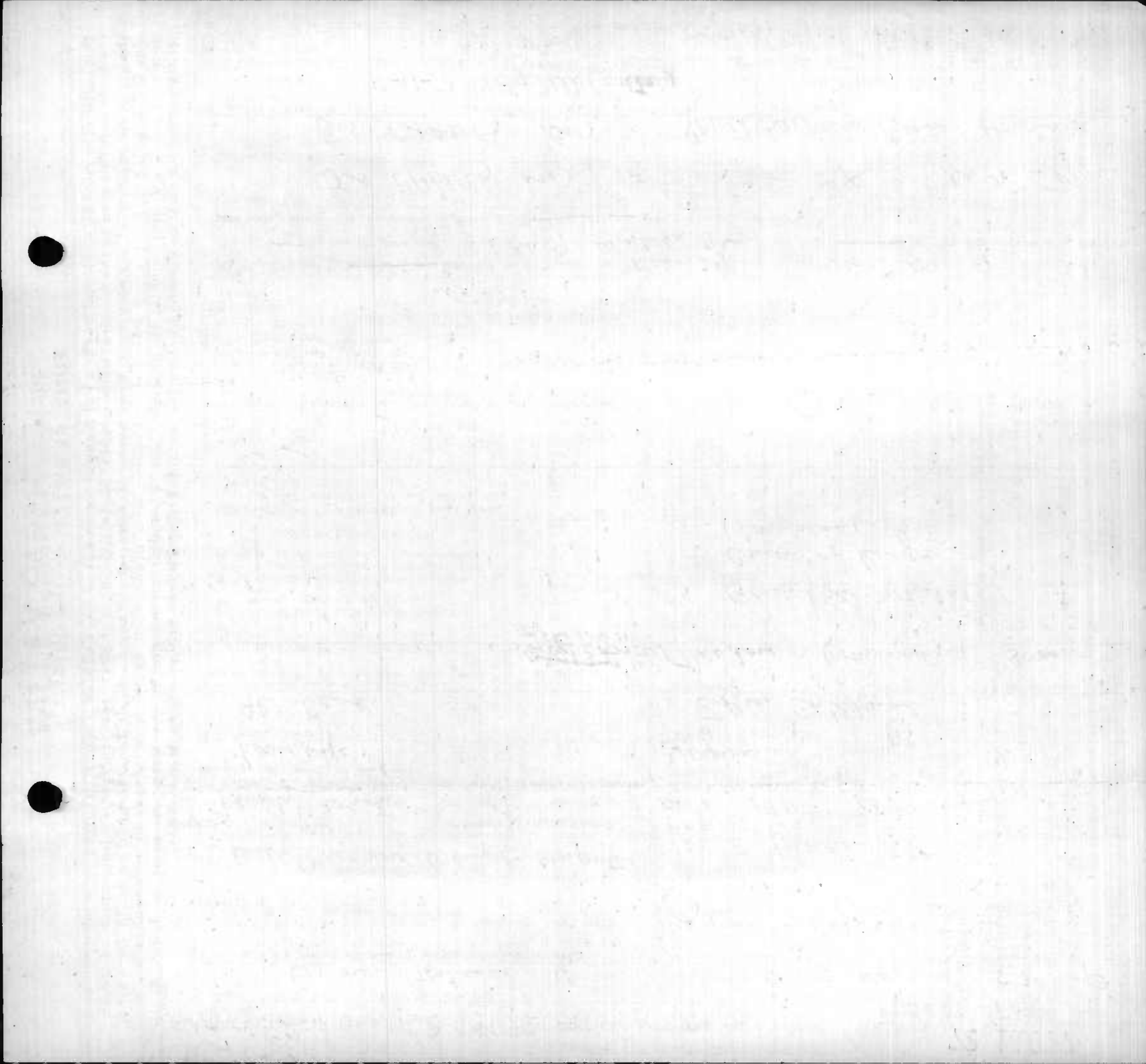
[Illegible text block]

[Illegible text block]

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

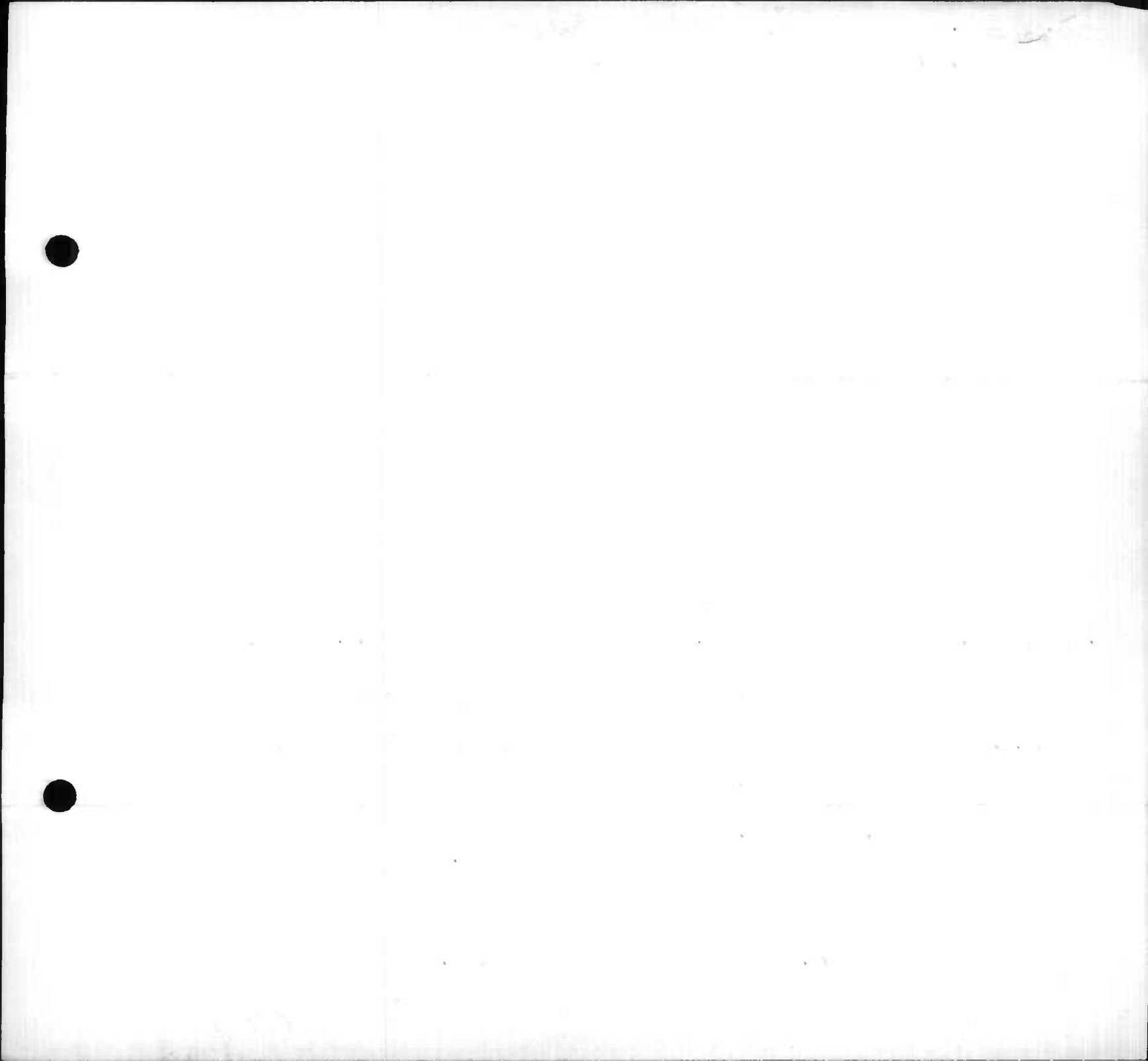
BALTIMORE CITY HEALTH DEPARTMENT				72 11677		REG. NO. 72 11677	
G-652				72 11677 CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		Grimes Gertrude V.		2. DATE AND HOUR OF DEATH		Dec. 7, 1972. 5:30. P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Maryland		B. COUNTY Baltimore	
South Baltimore General Hospital				C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 122 E. Hamburg St.							
5. SEX Female	6. RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 8, 1911	9. AGE in years (last birthday) 60	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Al Brooks				14. MOTHER'S MAIDEN NAME Effie Childress			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 0301381067		17. INFORMANT Theodore (Husband)		ADDRESS Same.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				19. CAUSE OF DEATH (A) IMMEDIATE CAUSE Generalized metastatic Cancer of lungs. (Carcinoma) (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) <del>(this hospital)</del> attended the deceased from Nov. 29, 1972 to Dec. 7, 1972, that (I) <del>(we)</del> last saw the deceased alive on Dec. 7, at 5:30 p.m. 1972 and that in <del>(my)</del> <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> <del>(did)</del> <del>(did not)</del> view the body after death.							
23A. SIGNATURE J. S. CHANG, M.D.				23B. DATE SIGNED Dec 7, 1972.			
23C. PHYSICIAN'S NAME (Type) J. S. CHANG, M.D.				23D. ADDRESS South Baltimore General Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-11-72		24C. NAME OF CEMETERY OR CREMATORY Rocky Hill Cemetery		24D. LOCATION (City, town, or county) (State) Woodsboro, Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1972		25B. NAME OF REGISTRAR Audrey Robinson		25C. FUNERAL DIRECTOR McCully Funeral Home		ADDRESS 130 E. Fort Ave. 21230	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 11678		REG. NO. 72 11678	
BIRTH NO. P-400				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>John J. Paul</i>				2. DATE AND HOUR OF DEATH <i>Dec. 5, 1972</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>43 South Baltimore Gen. Hospital</i>				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>2301</i>			
5. SEX <i>M</i>				6. RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Self Employed</i>				10B. KIND OF BUSINESS OR INDUSTRY <i>?</i>		8. DATE OF BIRTH <i>April 19, 1919</i>	
13. FATHER'S NAME <i>Samuel Paul</i>				14. MOTHER'S MAIDEN NAME <i>Gertie Bixler</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes U.S.A.</i>				16. SOCIAL SECURITY NO. <i>202-05-1132</i>		9. AGE (In years last birthday) <i>53</i>	
11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
17. INFORMANT <i>Mrs. Lonnie Paul (Wife)</i>				ADDRESS <i>1818 S. Charles St.</i>			
18. <i>410.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Acute Myocardial Infarction</i>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>April 17</i> 19 <i>71</i> to <i>July</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>July 5</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>[Signature]</i>				23B. DATE SIGNED <i>12/6/72</i>		23C. PHYSICIAN'S NAME (Type) <i>RICARDO LOZADA M.D.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>				24B. DATE		24C. NAME of CEMETERY or CREMATORY <i>Evergreen Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Standardsville, Va.</i>				25A. DATE REC'D BY HEALTH DEPT. <i>DEC 8 1972</i>			
25B. NAME OF REGISTRAR <i>Lidney [Signature]</i>				25C. FUNERAL DIRECTOR <i>McGully Funeral Home</i>			
ADDRESS <i>130 E. Font Ave. 21230</i>							

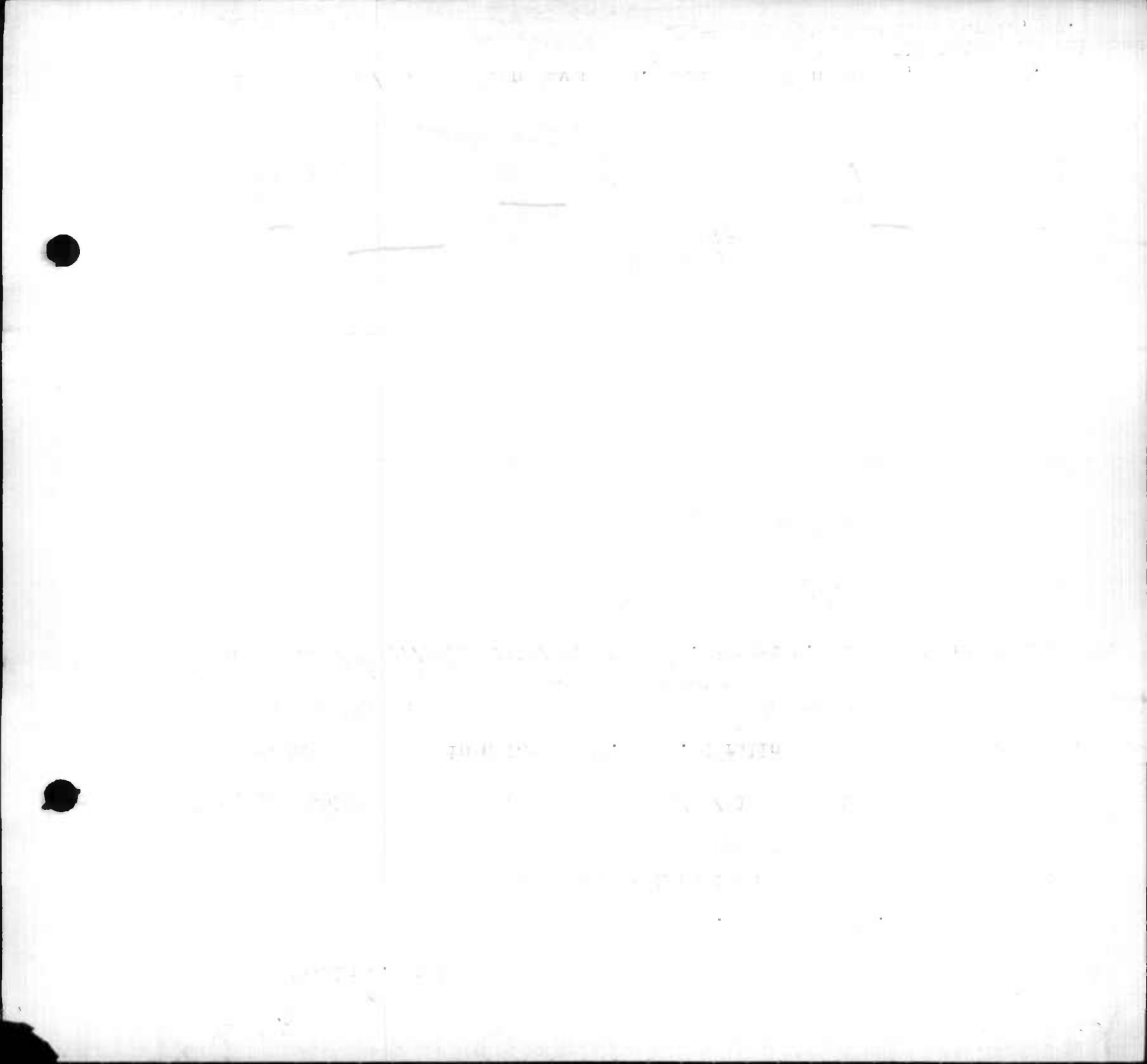




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 11679	
K-626		72 11679	
BIRTH NO.		72 11679	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
Mollie L. Kreiser		DEC. 7, 1972 11:05 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY	
SOUTH BALTIMORE GENERAL HOSPITAL 43		Md. AA Co.	
5. SEX		6. RACE	
FEMALE		white	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		4/16/91	
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
81		seamstress	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
N. Carolina		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
James Newsom		Ida UNKNOWN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
No		215/05/0823A	
17. INFORMANT		ADDRESS	
Mr. Robert L. Rodgers (son)		same as #4e	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			
ARTERIOSCLEROTIC CARDIOVASCULAR HEART DISEASE			
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
E.C.H.F.			
(B) HYPOPROTHROMBINEMIA DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____			
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
0			
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Nov. 27, 1972 to DEC. 7, 1972 that (I) (we) last saw the deceased alive on DEC 7, 1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE		23B. DATE SIGNED	
Duck Sung Chun, M.D.		DEC. 7 '72	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
DUCK SUNG CHUN, M.D.		SOUTH BALTO GEN. HOSP. 3201 S. HANOVER ST. BALTO, MD. 21230	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
Burial		12/11/72	
24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Glen Haven Mem. Park		Glen Burnie, AA Co Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
DEC 8 1972		Audrey M. Heston	
25C. FUNERAL DIRECTOR		ADDRESS	
David Heston		Singleton Funeral Home Glen Burnie, Md.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 11680	
P-654				72 11680	
BIRTH NO.				72 11680	
1. NAME OF DECEASED (Type or Print) WILLIAM L. PURNELL			2. DATE AND HOUR OF DEATH 12/6/72 900 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SOUTH BALTIMORE GENERAL HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY 2505 C. CITY OR TOWN BALTO. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4217 MORRISON CT.		
5. SEX male	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-30-09	9. AGE (In years last birthday) 63	10. CITIZEN OF WHAT COUNTRY? U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boilermaker			11. BIRTHPLACE (State or foreign country) LA.		
13. FATHER'S NAME UNK.			14. MOTHER'S MAIDEN NAME UNK.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> 8-7-42 - 7-26-56			16. SOCIAL SECURITY NO. 216-09-1019		
17. INFORMANT			ADDRESS		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) PNEUMONIA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CHRONIC OBSTRUCTIVE AIRWAY DISEASE Possible Ruptured Aorta II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS SEVERAL YRS.		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/6/72 to 12/6/72, and that (I) (we) last saw the deceased alive on 12/6/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert J. Bauer, M.D.				23B. DATE SIGNED 12/6/72	
23C. PHYSICIAN'S NAME (Type) ROBERT J. BAUER, M.D.				23D. ADDRESS 3001 S. HANOVER ST. BALTIMORE, MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-9-72		24C. NAME OF CEMETERY or CREMATORY Cedar Hill	
24D. LOCATION Ridgely Hwy BALTO. MD.		24E. NAME OF REGISTRAR Ardrey Johnston		24F. FUNERAL DIRECTOR HARRIS Funeral Home 4200 Pennington Ave	
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1972		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	

DATE OF BIRTH: 01-01-1968  
PLACE OF BIRTH: [illegible]

CHINESE OBSERVING FROM THE PAST

● 2006 年 10 月 1 日起

2014 BULLWINKLE CEMENT MOUNT

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 11681</u>	
C-160 72 11681				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
COOPER, ARTHUR CLEVELAND		DECEMBER 8, 1972   9:20 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION  ST AGNES HOSPITAL		A. STATE MARYLAND		B. COUNTY 1902	
5. SEX MALE		6. RACE CAUCASIAN		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 8/7/92		9. AGE (In years last birthday) 80		10. CITIZEN OF WHAT COUNTRY? USA	
11. BIRTHPLACE (State or foreign country) KENTUCKY		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME GEORGE COOPER		14. MOTHER'S MAIDEN NAME Rhoda Barton			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 407 20 9796		17. INFORMANT ST AGNES HOSPITAL-BALTO., MD.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  CAUSE OF DEATH CA - Jaw		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:			
21. MEDICAL CERTIFICATION 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from 11 22 1972 to 12 8 1972 that (X) (we) last saw the deceased alive on 12 8 1972 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death.		23A. SIGNATURE L BUCKLER M.D. 23B. DATE SIGNED 12 8 72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/11/72		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore City, Maryland		25A. DATE REC'D BY HEALTH DEPT. DEC 8 1972			
25B. NAME OF REGISTRAR Sidney H. Heston		25C. FUNERAL DIRECTOR Walters Funeral Home Pratt & Stricker			
25D. ADDRESS Streets 21223					

• 1911 12

100

•

00000

•

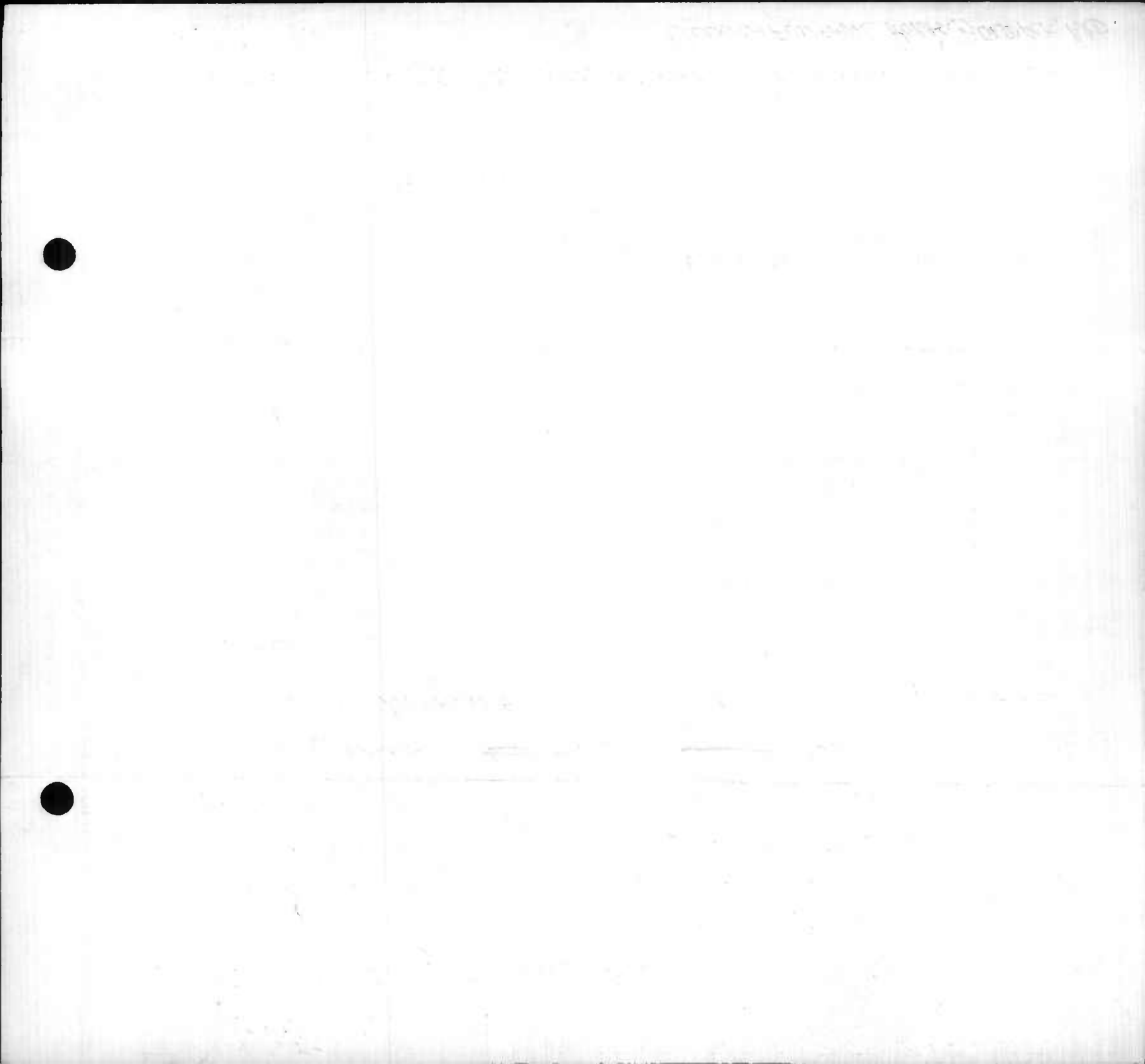


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-245		72 11682		BALTIMORE CITY HEALTH DEPARTMENT		72 11682	
CERTIFICATE OF DEATH				STATE OF MARYLAND			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Wickline, Charles M.</i>		2. DATE AND HOUR OF DEATH <i>12-8-72 8 20 AM</i>		REG. NO.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>North Charles Gen. Hospital</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>27th &amp; N. Charles St.</i>		A. STATE <i>Md.</i>		B. COUNTY <i>Baltimore</i>	
				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <i>237 St. Helena Lane 21222</i>			
5. SEX <i>Male</i>	6. RACE <i>Caucasian</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>9-11-04</i>	9. AGE (in years lost birthday) <i>68</i>	10. Under 1 Yr. Months	11. Under 24 Hrs. Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Mechanic</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>AA. SMELTING</i>		11. BIRTHPLACE (State or foreign country) <i>U.S.A. OHIO</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Thomas Wickline</i>				14. MOTHER'S MAIDEN NAME <i>Lauderbach, Rachel</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>None</i>		16. SOCIAL SECURITY NO. <i>232-14-7202</i>		17. INFORMANT <i>Patients' chart</i>		ADDRESS <i>NCCH</i>	
18. <i>162.1 I</i> CAUSE OF DEATH						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.</i>				(A) IMMEDIATE CAUSE <i>Progressive resp. failure</i>		<i>4 weeks -</i>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <i>Chronic Emphysema - post pneumonectomy</i>			
				(C) <i>8 years ago for malignancy.</i>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>10-21-72</i> 19 to <i>12-8-72</i> 19 that (I) (we) last saw the deceased alive on <i>12/8/72</i> 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Dunbar</i>				23B. DATE SIGNED <i>12/8/72</i>		23C. PHYSICIAN'S NAME (Type) <i>Dunbar</i>	
23D. ADDRESS <i>North Charles General Hospital</i>				23E. DEGREE			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>11 Dec. 72</i>		24C. NAME OF CEMETERY or CREMATORY <i>OAK LAWN CEMETERY</i>		24D. LOCATION (City, town, or county) (State) <i>BALTIMORE COUNTY, MD.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 8 1972</i>		25B. NAME OF REGISTRAR <i>Andrew Johnson</i>		25C. FUNERAL DIRECTOR <i>Ulrich Funeral Home, Dundalk, Md.</i>		ADDRESS	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO.	
M-635		72 11683		72 11683			
1. NAME OF DECEASED (Type or Print) <u>Oscar F. Martinson</u>				2. DATE AND HOUR OF DEATH <u>Dec. 8, 1972</u> <u>8:03 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Bon Secours Hospital</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u>			
				C. CITY OR TOWN <u>Balto.</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <u>1313 Birch Ave.</u>			
5. SEX <u>Male</u>	6. RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/14/13</u>	9. AGE (In years last birthday) <u>59</u>	11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>CAN</u>				
13. FATHER'S NAME <u>Sigvart Martinson</u>				14. MOTHER'S MAIDEN NAME <u>Clara Karlson</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>214-03-6997</u>		17. INFORMANT <u>Chart</u>		
18. <u>250.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Pulmonary emboli - block</u> (B) <u>Thrombophlebitis - CHF</u> (C) <u>Diabetes</u>			
19A. DATE OF OPERATION <u>0</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>November 24, 1972</u> to <u>December 8, 1972</u> that (I) (we) last saw the deceased alive on <u>10:03 AM 12-8-1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>A. Paberi, M.D.</u>				23B. DATE SIGNED <u>12-8-72</u>		23C. PHYSICIAN'S NAME (Type) <u>PABERI-GHOUGHAN</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>12/11/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Dorsey, Howard, Maryland</u>				25A. DATE REC'D BY HEALTH DEPT. <u>DEC 8 1972</u>			
25B. NAME OF REGISTRAR <u>Andrew...</u>				25C. FUNERAL DIRECTOR <u>Am Bros Co 1328 Sulphur Sp Rd</u>			

10/1/02

10/1/02

10/1/02

10/1/02

10/1/02

10/1/02

10/1/02

10/1/02

10/1/02

72 11684

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 11684

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>OWEN W. BALDWIN</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> December 1, 1972 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>33 JOHNS HOPKINS HOSPITAL</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour December 1, 1972 12:25 P.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Lexington Park	
9. DATE OF BIRTH Feb. 23, 1912		10. AGE (In years last birthday) 60	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME David Horace Baldwin		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY St Mary's	
15. MOTHER'S MAIDEN NAME Ellen Russell		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 003 03 1205		18. INFORMANT Baldwins Store Vivian R. Baldwin Lexington Park, Maryland	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  20A. DATE OF OPERATION 2 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of prostate with multiple metastases 21. AUTOPSY? (Yes or No) yes		22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 22D. TIME OF INJURY (APPROX.) 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> 22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <i>Ronald N. Kornblum</i> M.D. Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/2/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/6/1972	
24C. NAME of CEMETERY or CREMATORY Cross Creek Cemetery		24D. LOCATION (City, town, or county) (State) Fayetteville, Cumberland, North Carolina	
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1972		25B. NAME OF REGISTRAR <i>A. J. ...</i>	
25C. FUNERAL DIRECTOR W. Clarke Mattingley		25D. ADDRESS Leonardtwn, Maryland	

Form with multiple sections and fields, including a large header area at the top and a footer area at the bottom. The text is faint and mostly illegible due to the quality of the scan. The form appears to be a standard administrative or reporting document.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 11685	
H-160 72 11685				STATE OF MARYLAND-DEPT.	
BIRTH NO.				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Charles John Hoover, SR.			2. DATE AND HOUR OF DEATH 12-7-72 3 50 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY 2003		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Md. Gen. Hosp. 48			C. CITY OR TOWN Balt. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER 1928 1/2 W. Pratt St. 21223		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-16-30	9. AGE (in years last birthday) 42	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator			10B. KIND OF BUSINESS OR INDUSTRY Md. Glass Co.		
11. BIRTHPLACE (State or foreign country) Md.			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Charles E. Hoover			14. MOTHER'S MAIDEN NAME Virginia (Unknown)		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 212-26-0337		
17. INFORMANT Mrs. Shirley Hoover, 1928 1/2 W. Pratt St.			ADDRESS 21223		
18. CAUSE OF DEATH 287.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
(A) IMMEDIATE CAUSE Pulmonary Edema, acute DUE TO, OR AS A CONSEQUENCE OF:					
(B) Suspected Pulmonary emboli DUE TO, OR AS A CONSEQUENCE OF:					
(C) Henoch-Schoenlein Disease					
19A. DATE OF OPERATION 2			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) Kidneys only			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 12-7-1972 to 12-7-1972 that (I) (we) last saw the deceased alive on 12-7-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Arnold G. Alexander MD			23B. DATE SIGNED 12-7-72		
23C. PHYSICIAN'S NAME (Type) Arnold G. Alexander MD			23D. ADDRESS 827 Linden Ave 21201		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			24B. DATE 12-11-72		
24C. NAME of CEMETERY or CREMATORY Most Holy Redeemer Cemetery			24D. LOCATION (City, town, or county) (State) Baltimore Maryland		
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1972			25B. NAME OF REGISTRAR Sidney Johnston		
25C. FUNERAL DIRECTOR Hubbard Funeral Home, Inc. 4107 Wilkens Ave.			ADDRESS 21229		

1922

7-1-

THE JOURNAL OF THE

1922

1922



B-653

72 11686

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 11686

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mabel G. Brundrett		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 12 7 72 2:59 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 St. Agnes Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 7 72 2:59 P.M.	
6. SEX Female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Howard	
9. DATE OF BIRTH 5 Dec. 1899		10. AGE (in years last birthday) 73	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Herbert W. Brundrett		14. MOTHER'S MAIDEN NAME Emma A. Williams	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk - Ret.		16. KIND OF BUSINESS OR INDUSTRY Gas & Electric Co.	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		18. SOCIAL SECURITY NO.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E815.10 Multiple injuries DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
21. DATE OF OPERATION 2		22. CONDITION FOR WHICH OPERATION WAS PERFORMED	
23. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH 24. TIME (Month) (Day) (Year) (Hour) (P.M.) 12 7 72 2:45 P.M.		25. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street 26. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
27. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Old Washington Blvd. 500' N. of Montgomery Rd.		28. HOW DID INJURY OCCUR? Driver in auto-fixed object accident	
29. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
30. ACTUAL SIGNATURE EXAMINER'S NAME (Type) William P. Mulloy, M.D.		31. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12-8-72	
32. DATE REC'D BY HEALTH DEPT. DEC 8 1972		33. NAME OF REGISTRAR Sidney J. Boston	
34. DATE OF BURIAL 11 Dec. 72		35. NAME OF CEMETERY or CREMATORY Meadowridge Memorial Park	
36. LOCATION (City, town, or county) Elkridge, Howard Co., Md.		37. FUNERAL DIRECTOR Kirkley Funeral Home, Glen Burnie, Md.	

DO

17 X - f

12 100.00

100.00

3

72 11687		BALTIMORE CITY HEALTH DEPARTMENT		72 11687	
<b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b>					
BIRTH NO.		REG. NO.			
1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH		3. DATE PRONOUNCED DEAD	
Gilbert Young		Known <input checked="" type="checkbox"/> Month 12 Day 7 Year 72 Hour 8:39 P.M. Estimated <input type="checkbox"/> 12 7 72 8:39 P. M.		Month 12 Day 7 Year 72 Hour 8:39 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION		5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Union Memorial Hospital		A. STATE Maryland B. COUNTY 2758			
6. SEX	7. RACE	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN D. INSIDE CITY LIMITS?	
Male	White			Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH		10. AGE (In years last birthday)		E. STREET AND NUMBER	
April 16, 198		74		XXXXXX XXXX 5815 Willowton Ave,	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
Maryland		USA		UNKNOWN Arthur J. Young	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME	
Cement Inspector				Margaret Clocker	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS	
No		213-20-5352		Mr. Harry A. Young Same	
19. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
(A) IMMEDIATE CAUSE Hypertensive & arteriosclerotic DUE TO, OR AS A CONSEQUENCE OF: cardiovascular disease					
(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			21. AUTOPSY? (Yes or No)
2					Yes
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED		22F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
23.					
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		DATE SIGNED	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER		12-8= 72	
William P. Mulloy, M.D.		ASSOCIATE MEDICAL EXAMINER			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		12/9/72		Parkwood	
24D. LOCATION (City, town, or county) (State)		24E. FUNERAL DIRECTOR ADDRESS			
Balto, Md.		Leonard J. Ruck Inc. Balto. Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
DEC 8 1972		L. J. Ruck		Leonard J. Ruck Inc. Balto. Md.	

W/AM

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 11688		REG. NO. 72 11688	
BIRTH NO. <u>M-620</u>				72 11688			
1. NAME OF DECEASED (Type and Print) <b>MYERS, MARY ELIZABETH</b>				2. DATE AND HOUR OF DEATH <b>DECEMBER 1, 1972 3:00 A</b> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>ST AGNES HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>HOWARD COUNTY</b> C. CITY OR TOWN <b>JESSUP</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>BOX 7861 JONES ROAD 20794</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>07 04 96</b>	9. AGE (In years last birthday) <b>76</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>JOHN H. HOLLAND</b>				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <b>RECORD 1'S BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS &amp; CATON AVE</b>		
18. <b>410-91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Recent extensive Myocardial infarction</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Arteriosclerotic heart disease</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Chronic renal failure</b>							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>OCTOBER 28, 19 72</b> to <b>NOVEMBER 1, 19 72</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>DECEMBER 1, 19 72</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.							
23A. SIGNATURE <b>Vincent H. Wang M.D.</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>12/1/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>VINCENT H. WANG M.D.</b>				23D. ADDRESS <b>BALTO MD 21229 ST AGNES HOSPITAL WILKENS &amp; CATON AVE</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-5-72</b>		24C. NAME of CEMETERY or CREMATORY <b>Asbury Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Jessups, Howard Co. Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 8 1972</b>		25B. NAME OF REGISTRAR <b>Sidney Robinson</b>		25C. FUNERAL DIRECTOR <b>George R. Snowden</b>		ADDRESS <b>Rockville MD</b>	

ATMOSPHERIC WINDS WIND

ST. JOHN'S HOSPITAL WILKINS & SONS LTD  
BAGGAGE NO 31338

X XXXX

DECEMBER 1

15

XX

DECEMBER 15

15

XXXXXXXXXX

15

ST. JOHN'S HOSPITAL WILKINS & SONS LTD  
BAGGAGE NO 31338

ATMOSPHERIC WINDS WIND

ATMOSPHERIC

15

ATMOSPHERIC WINDS WIND

ATMOSPHERIC

15

ATMOSPHERIC WINDS WIND

ATMOSPHERIC WINDS WIND

15

ATMOSPHERIC

15

ATMOSPHERIC

ATMOSPHERIC

ATMOSPHERIC

ATMOSPHERIC WINDS WIND

ATMOSPHERIC WINDS WIND

15



## CERTIFICATE OF DEATH

REG. NO.

72 11689

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

WILKERSON LORENZO B.

2. DATE AND HOUR OF DEATH

11-30-72

12.15 P.M.

STATE OF MARYLAND-DEPT

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Baltimore City Hospital  
4940 Eastern Avenue  
Baltimore, Md. 21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Delaware

C. CITY OR TOWN

Dagsboro

D. INSIDE CITY LIMITS?

YES ☐NO ☐

E. STREET AND NUMBER

Main Street, Box 173 19939

5. SEX

MALE

6. RACE

CAUCASIAN

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

Oct. 21, 1928

9. AGE (In years last birthday)

44

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired Sales

10B. KIND OF BUSINESS OR INDUSTRY

-

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Lorenzo B. Wilkerson Sr.

14. MOTHER'S MAIDEN NAME

Etta B. Wilkerson

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

221-16-2784

17. INFORMANT

BCH RECORDS 4940 Eastern Ave., 21224

ADDRESS Baltimore, Md.

18. 162.1 I

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

Brain Hypertension

6/72

(B) IMMEDIATE CAUSE

Brain metastasis

6/72

(C) IMMEDIATE CAUSE

adenocarcinoma of lung

8/72

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

16/72 and 19/72 Round lesions. Renal transplant

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

Brain scan showed

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10-24 1972 to 11-30 1972 that (I) (we) last saw the deceased alive on 11-30 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Arturo J. Salazar M.D.

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

11-30-72

23C. PHYSICIAN'S NAME (Type)

ARTURO J. SALAZAR MD.

23D. ADDRESS 4940 Eastern Ave., Baltimore, Md. 21224

Baltimore City Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

12/5/72

24C. NAME OF CEMETERY OR CREMATORY

Dagsboro Cemetery

24D. LOCATION

Dagsboro, Sussex, Del.

(City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT.

DEC 8 1972

25B. NAME OF REGISTRAR

Sidney Wilkerson

25C. FUNERAL DIRECTOR

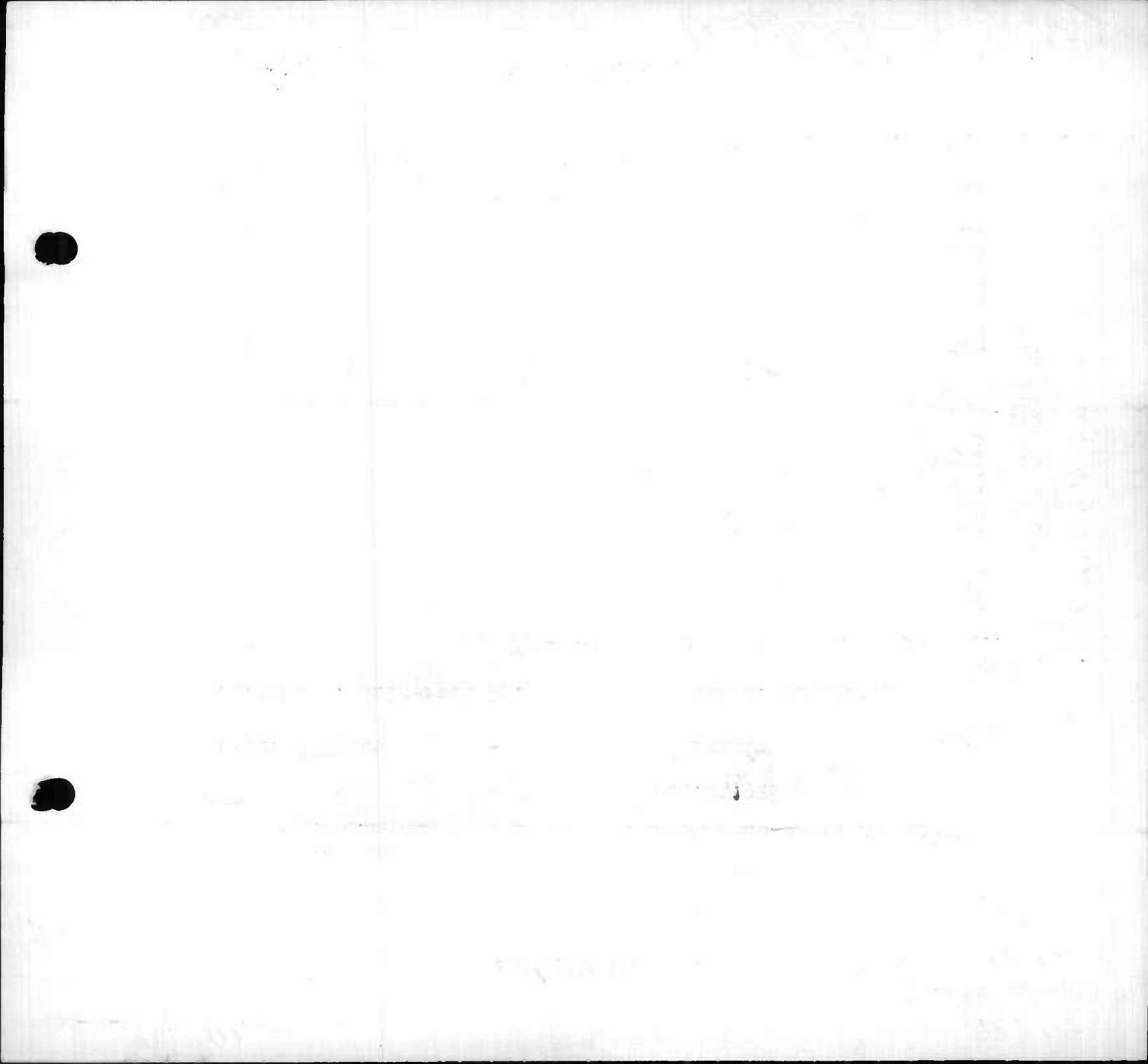
B. Salazar, Md., Fairfax, Del.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

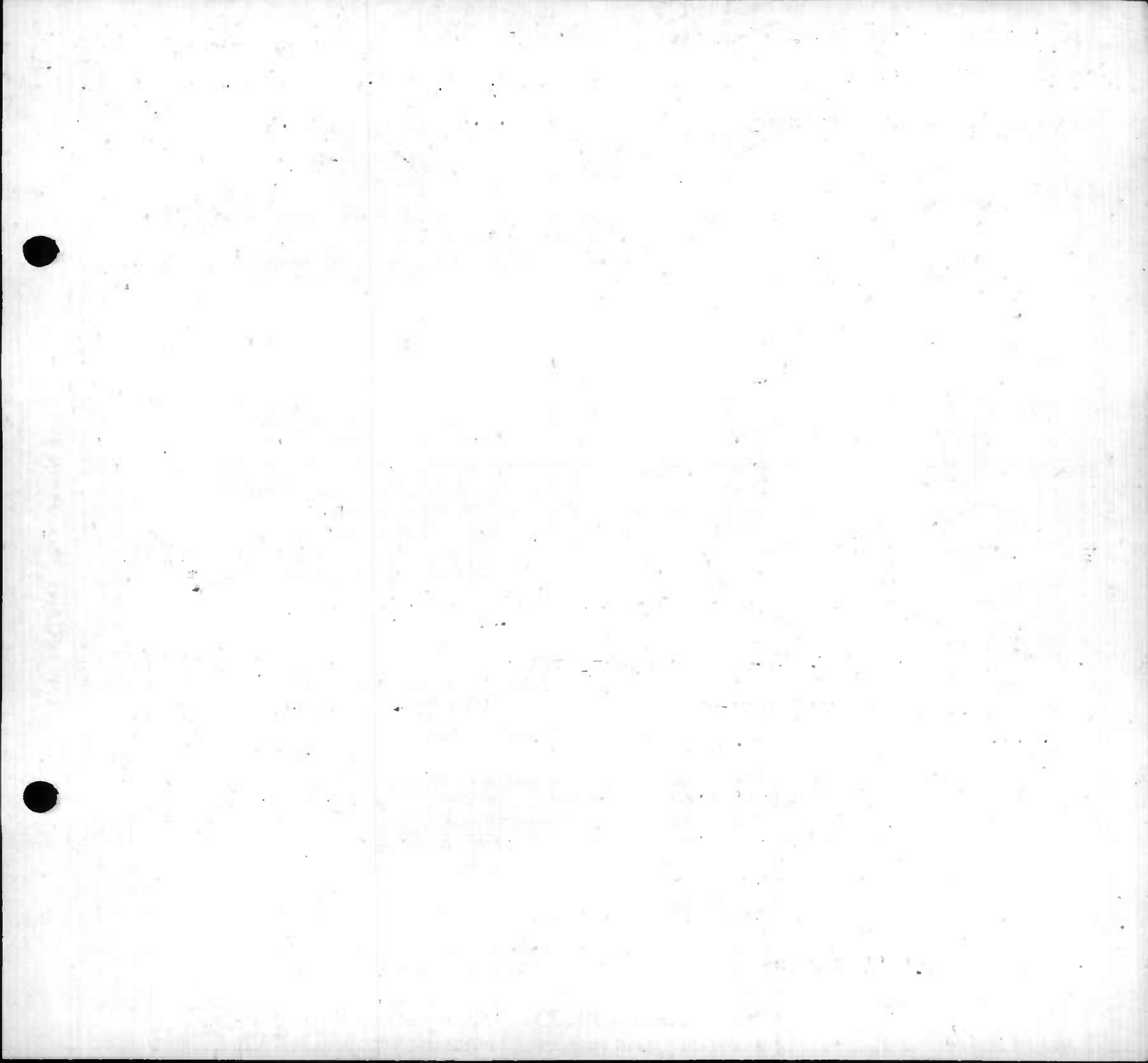




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

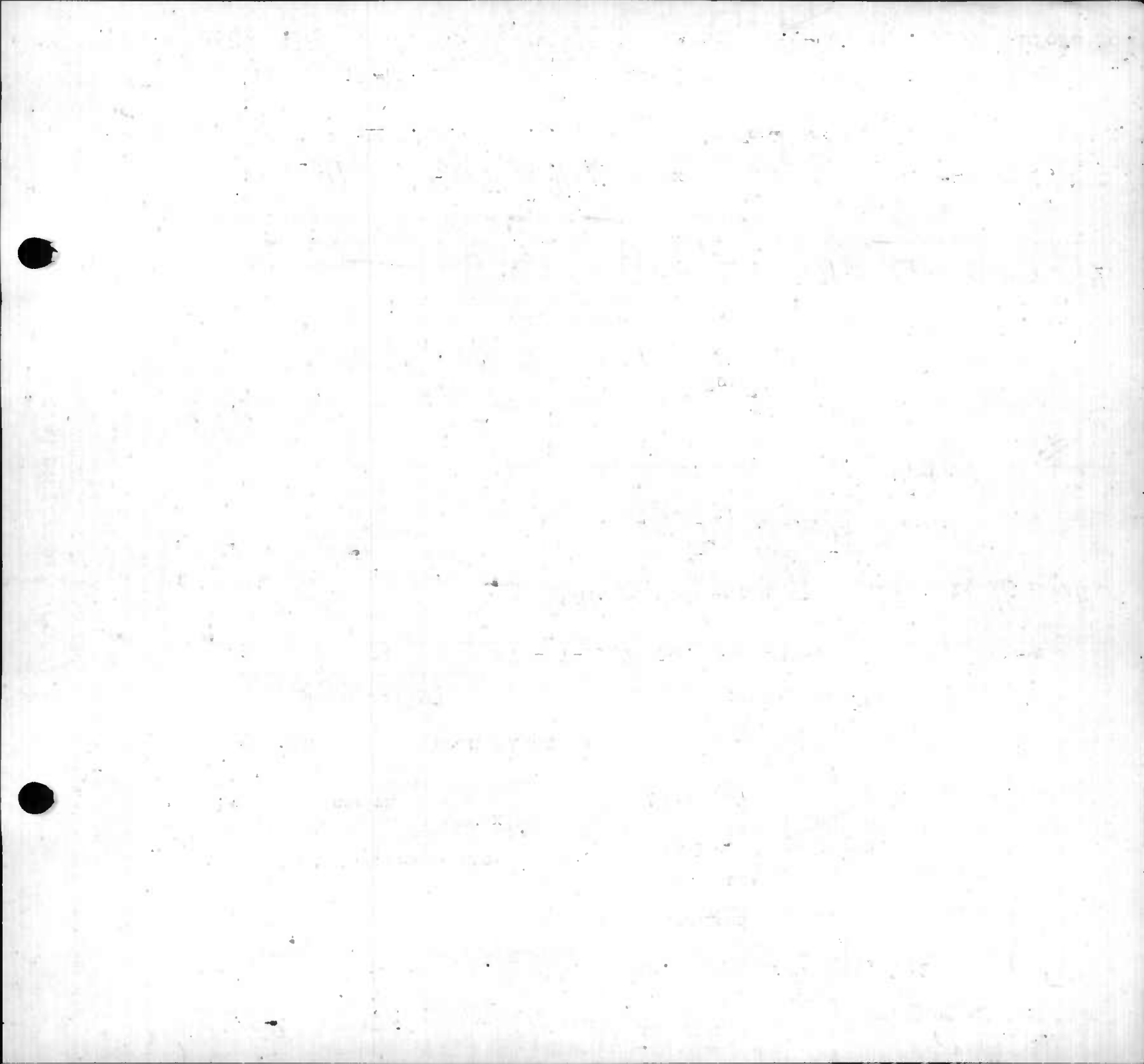
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.2em;">72 11690</span>	
B-263 <span style="font-size: 1.2em;">72 11690</span>				STATE OF MARYLAND-DEME	
BIRTH NO.			72 11690		
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Mary Louise Bussard</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">December 7, 1972   2130 A. M.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.5em;">00</span>			A. STATE <span style="font-size: 1.2em;">Maryland</span>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">4723 Hazelwood Ave</span>			C. CITY OR TOWN <span style="font-size: 1.2em;">Baltimore</span>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <span style="font-size: 1.2em;">4723 Hazelwood Ave</span>		
5. SEX <span style="font-size: 1.2em;">Female</span>	6. RACE <span style="font-size: 1.2em;">White</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">Nov. 15, 1916</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">56</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Housewife</span>			11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Penna.</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>
13. FATHER'S NAME <span style="font-size: 1.2em;">Charles C Heilmann</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Cecelia Dieter</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>			16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">212-09-9960</span>		17. INFORMANT <span style="font-size: 1.2em;">Mr George C Bussard</span>
			ADDRESS <span style="font-size: 1.2em;">Same</span>		
18. <span style="font-size: 1.5em;">348.01</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenic, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH <span style="font-size: 1.2em;">Amyotrophic lateral sclerosis</span> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">2 yrs</span>					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0 -</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">no</span>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">1970</span> to <span style="font-size: 1.2em;">Dec 7</span> 1972, that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">Dec 6</span> 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Duer Moores M.D.</span>				23B. DATE SIGNED <span style="font-size: 1.2em;">12-8-72</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">D. Duer Moores M.D.</span>				23D. ADDRESS <span style="font-size: 1.2em;">3105 Belair Rd Baltimore, Maryland</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">12/11/72</span>		24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">Gardens Of Faith</span>	
				24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Maryland</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">DEC 8 1972</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Sidney [Signature]</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Leonard J Ruck Inc. Baltimore, Md</span>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 11691		REG. NO. 72 11691	
BIRTH NO. 72 11691		CERTIFICATE OF DEATH		STATE OF MARYLAND-DEATH	
1. NAME OF DECEASED (Type or Print) <b>EDWARD F. WILLEM Sr.</b>			2. DATE AND HOUR OF DEATH <b>DECEMBER 7, 1972 9:50 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>00 3311 Southern Avenue</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2743</b>		
5. SEX <b>Male</b>			6. RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>4/8/1907</b>			9. AGE (In years last birthday) <b>65</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Todd Cigarette</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>John Willem</b>		
14. MOTHER'S MAIDEN NAME <b>Emelie Thom</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>214-01-5347</b>			17. INFORMANT <b>Mrs. Mary Willem</b>		
18. ADDRESS <b>Same</b>			19. CAUSE OF DEATH		
1B. <b>153.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <b>Adenocarcinoma of Transverse Colon</b> DUE TO, OR AS A CONSEQUENCE OF: <b>abdominal and liver metastases</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>16 months</b>			21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		
19A. DATE OF OPERATION <b>0</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) <b>No</b>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <b>Aug. 2</b> 19 <b>71</b> to <b>December 7</b> 19 <b>72</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>Dec 6</b> 19 <b>72</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <b>Harold V. Harbold M.D.</b>			23B. DATE SIGNED <b>December 8, 1972</b>		
23C. PHYSICIAN'S NAME (Type) <b>Harold V. Harbold M.D.</b>			23D. ADDRESS <b>4706 Harford Road</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/11/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Parkwood Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Baltimore Maryland</b>		24E. STATE <b>Maryland</b>		24F. ZIP CODE <b>21206</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 8 1972</b>		25B. NAME OF REGISTRAR <b>Lidny</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc.</b>	
25D. ADDRESS <b>5305 Harford Rd.</b>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-650 72 11692				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 11692	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>MARJORIE E. BROWN.</b>				2. DATE AND HOUR OF DEATH <b>12/07/72 10 53 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>UNION MEMORIAL HOSPITAL 44</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2706</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2213 LOUISE AVE. BALTO. 21214</b>			
5. SEX <b>F</b>	6. RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>04/12/1899</b>	9. AGE (In years last birthday) <b>73</b>	10. Under 1 Yr. Months: Days	11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>JOHN WEBSTER</b>			14. MOTHER'S MAIDEN NAME <b>NORTHAM, Mae</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>220-30-6961</b>		17. INFORMANT <b>Mrs. Frances Spicer</b>		ADDRESS <b>Same</b>
18. <b>4/12/21</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <b>0</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>11-19 1972</b> to <b>12-07 1972</b> , that (I) (we) last saw the deceased alive on <b>12-07 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Hermann Wendorff</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>12-07-72</b>	
23C. PHYSICIAN'S NAME (Type) <b>HERMANN WENDORFF</b>				23D. ADDRESS <b>UNION MEMORIAL HOSP.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/11/72</b>		24C. NAME of CEMETERY or CREMATORY <b>Lorraine Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 8 1972</b>				25B. NAME OF REGISTRAR <b>Leonard J. Ruck Inc.</b>			
				25C. FUNERAL DIRECTOR <b>5305 Harford Rd.</b>			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH									
REG. NO. 72 11693									
Z-456 BIRTH NO.		72 11693		X		STATE OF MARYLAND-DEATH			
1. NAME OF DECEASED (Type or Print) Rose S Zollner				2. DATE AND HOUR OF DEATH 12-7-72 9:15 A. M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 46 Lutheran Hosp.				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3025 Windsor Ave. 21229					
5. SEX Female	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/21/1892		9. AGE (In years last birthday) 80		10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10B. KIND OF BUSINESS OR INDUSTRY Clothing		11. BIRTHPLACE (State or foreign country) West Virginia			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME George F. Zollner Sr.				14. MOTHER'S MAIDEN NAME Agnes N. Unknown					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-10-8696		17. INFORMANT ADDRESS Mr. George V. Mouse 3209 Glendale Ave					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 412.41 A.S.C.V.D. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 12-15-1972 to 12-7-1972, that (I) (we) last saw the deceased alive on 12-4-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE Barbu Calin				23B. DATE SIGNED 12-7-72					
23C. PHYSICIAN'S NAME (Type) BARBU CALIN				23D. ADDRESS 831 Poplar Grove Balto. 21216					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/9/72		24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Maryland			
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1972		25B. NAME OF REGISTRAR Sidney Johnston		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc. 5305 Harford Rd.					

10/13/72 - Adm.  
Rev. Address: Georgia

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72-11694	
7-425 72-18254 72 11694				STATE OF MARYLAND-DEMR	
BIRTH NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>Falkner, Baby Boy</b>			12.6.72 8:20 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION <b>JOHNS HOPKINS HOSPITAL</b>			C. CITY OR TOWN <b>BALTIMORE</b>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
15. SEX <b>M</b>			8. DATE OF BIRTH <b>12.5.72</b>		
16. RACE <b>NEGRO</b>			9. AGE (In years last birthday) <b>16</b>		
17. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) <b>Johns Hopkins Hospital MARYLAND</b>		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>UNKNOWN</b>			14. MOTHER'S MAIDEN NAME <b>YVETTE FALKNER</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT			ADDRESS		
18. <b>74861</b>			CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE <b>HYPOXIA</b> DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) <b>PULMONARY HEMORRHAGE / PRIMARY LUNG DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF:		
			(C) <b>PREMATURITY</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>2 NONE</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) <b>Yes</b>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>No</b>		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that <b>HY</b> (this hospital) attended the deceased from <b>DEC 6</b> 19 <b>72</b> to <b>DEC 6</b> 19 <b>72</b> , that <b>HY</b> (we) last saw the deceased alive on <b>DEC 6</b> 19 <b>72</b> and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>HY</b> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>G. Gutcher, M.D.</b>			23B. DATE SIGNED <b>12.6.72</b>		
23C. PHYSICIAN'S NAME (Type) <b>G. GUTCHER, M.D.</b>			23D. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>			24B. DATE <b>12/7/72</b>		
24C. NAME OF CEMETERY or CREMATORY <b>Johns Hopkins Hospital</b>			24D. LOCATION (City, town, or county) (State) <b>601 N Broadway, Baltimore, Md.</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 8 1972</b>			25B. NAME OF REGISTRAR <b>Johns Hopkins Hospital</b>		
25C. FUNERAL DIRECTOR <b>Johns Hopkins Hospital</b>			25D. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>		

RECEIVED

RECEIVED

RECEIVED

RECEIVED

W-300

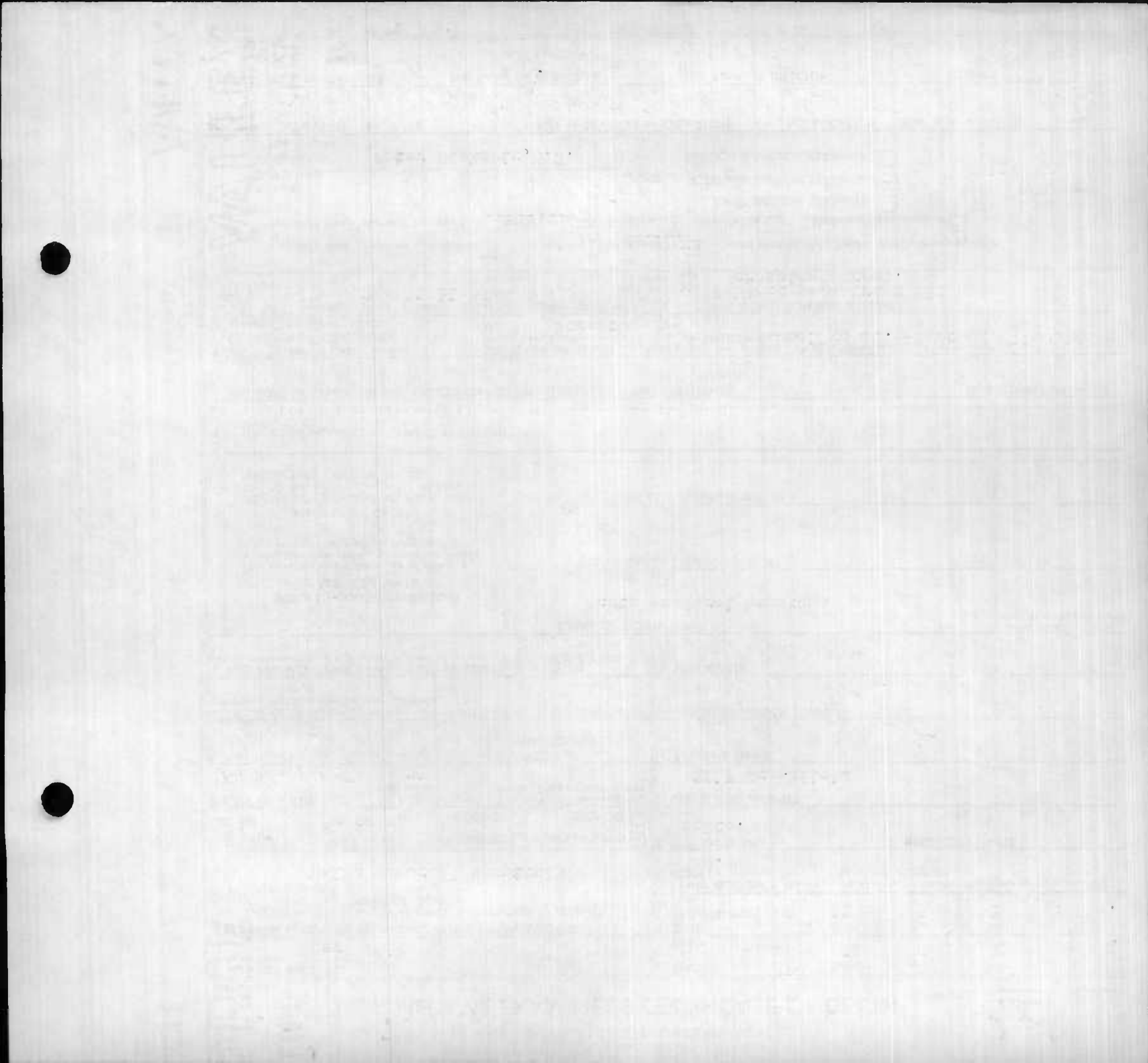
72 11695

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 11695

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Carl White				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 12 Day 5 Year 72 Hour M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 Union Memorial Hospital				3. DATE PRONOUNCED DEAD Month 12 Day 5 Year 72 Hour 8:15 a. M.			
6. SEX male				7. RACE Negro		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 1-11-1951				10. AGE (in years lost birthday) 21		E. STREET AND NUMBER 2217 Brookfield	
11. BIRTHPLACE (State or foreign country) North Carolina				12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Charles White	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Quincy Robinson	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				17. SOCIAL SECURITY NO. 219-50-0343		18. INFORMANT Quincy White ADDRESS Same	
19. E 814.7 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Acute subdural hematoma				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION 2				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 33rd St. - East of Ellerslie Avenue	
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) 12 3 72 11:55p				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Subject pedestrian hit by car while crossing street.	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic, M.D. EXAMINER'S NAME (Type)							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/9/72		24C. NAME OF CEMETERY or CREMATORY Baltimore		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1972		25B. NAME OF REGISTRAR A. J. [Signature]		25C. FUNERAL DIRECTOR [Signature]		ADDRESS 1727 N. Mount St.	



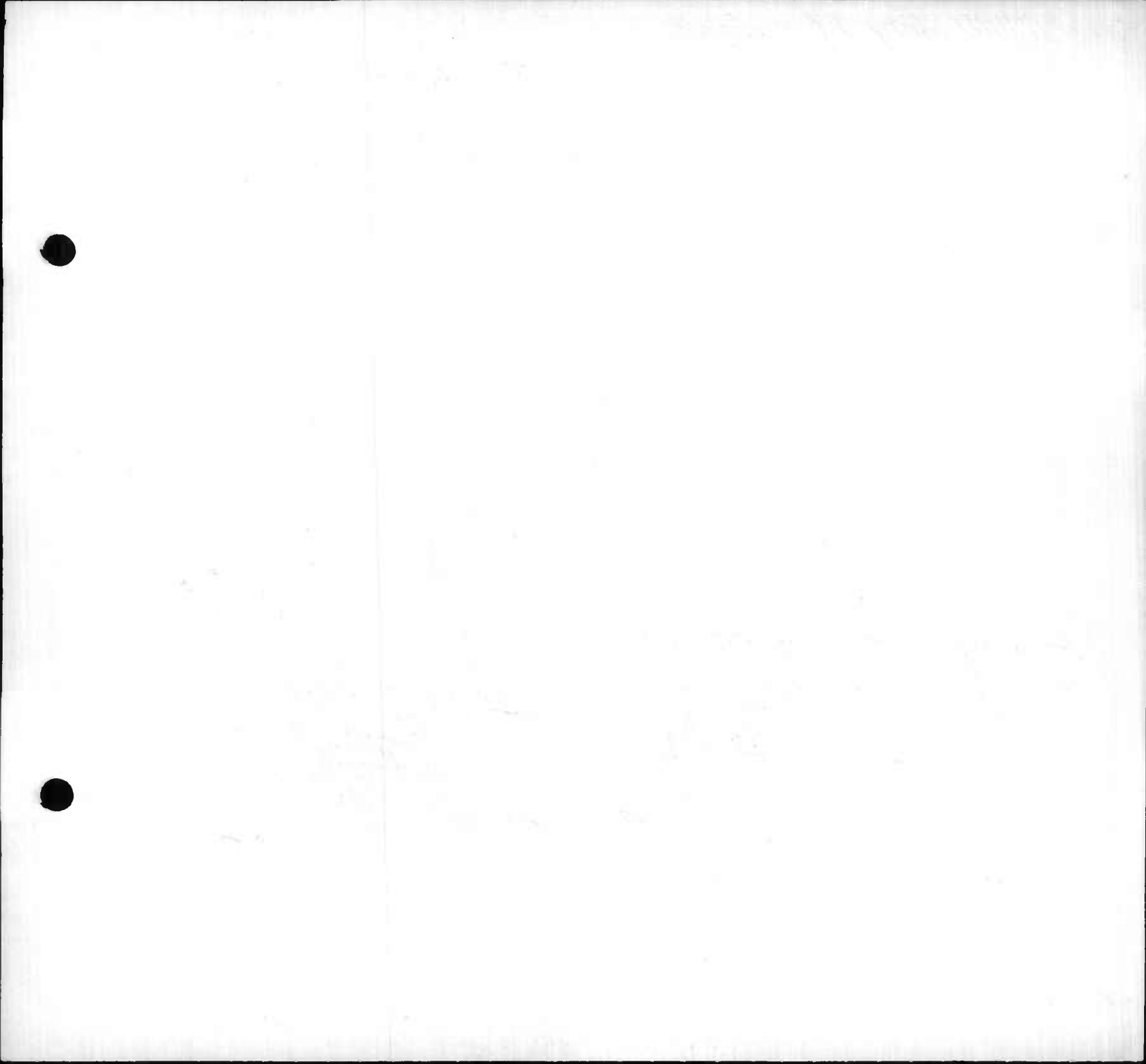


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 11686		REG. NO. 72 11686	
C-613				72 11686		STATE OF MARYLAND - DHMH	
BIRTH NO.				12/1/72 10:25 PM			
1. NAME OF DECEASED (Type or Print) <b>WILLIAM CORBETT</b>				2. DATE AND HOUR OF DEATH			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>UNIVERSITY OF MARYLAND HOSPITAL</b>				A. STATE <b>MD.</b>		B. COUNTY <b>1501</b>	
				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>1616 N GILMORE ST</b>			
5. SEX <b>M</b>	6. RACE <b>N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/16/25</b>	9. AGE (in years last birthday) <b>47</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY
13. FATHER'S NAME <b>Will Corbett</b>			14. MOTHER'S MAIDEN NAME <b>Gertrude Crenshaw</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Nazel Goode Same</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>513 X 1 + 250.9</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH <b>RUPTURED PULMONARY VESSEL</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>MULTIPLE LUNG ABSCESSSES</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 MIN</b> <b>7 days</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>SEPSIS, DIABETES MELLITUS</b>							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>0/27</b> 19 <b>72</b> to <b>12/1</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>12/1</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Thomas E. Murphy, Jr. MD</b>				23B. DATE SIGNED <b>12/1/72</b>		23C. PHYSICIAN'S NAME (Type) <b>THOMAS E. MURPHY, JR. MD</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>12-7-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		24D. LOCATION (City, town, or county) (State) <b>A.P.C. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 8 1972</b>		25B. NAME OF REGISTRAR <b>Franklin</b>		25C. FUNERAL DIRECTOR <b>William S. Phillips</b>		ADDRESS <b>1720 N. Mount St.</b>	





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 11697

REG. NO.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

CHARLES W. ROBINSON

2. DATE OF DEATH  
Known ☒ Estimated ☐ Month Day Year Hour  
December 7, 1972 M.4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF HOSPITAL OR INSTITUTION  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

2121 Moyer Street

3. DATE PRONOUNCED DEAD Month Day Year Hour  
December 7, 1972 11:42 AM5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE Maryland B. COUNTY 603

6. SEX

Male

7. RACE

White

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

JULY 18 1905

10. AGE (In years  
last birthday) 6711. Under 1 Yr. 11 Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

2121 Moyer Street

11. BIRTHPLACE (State or foreign country)

WEST VIRGINIA

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

UNK

14. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Retired

14B. KIND OF BUSINESS OR INDUSTRY

AMERICAN RADIATOR

15. MOTHER'S MAIDEN NAME

UNK

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL SECURITY NO.

705 077 178

18. INFORMANT

ADDRESS

Rosemary Robinson 2121 Moyer St

19.

412.41

CAUSE OF DEATH

Arteriosclerotic cardiovascular disease

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Marvin S. Platt, M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

December 7, 1972

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

Dec 9 1972

24C. NAME OF CEMETERY or CREMATORY

Crest Lawn Cem

24D. LOCATION (City, town, or county) (State)

RT 40

MARYLAND

25A. DATE REC'D BY HEALTH DEPT.

DEC 8 1972

25B. NAME OF REGISTRAR

Dipper, Bros

25C. FUNERAL DIRECTOR

1800 E Lombards

\_\_\_\_\_

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

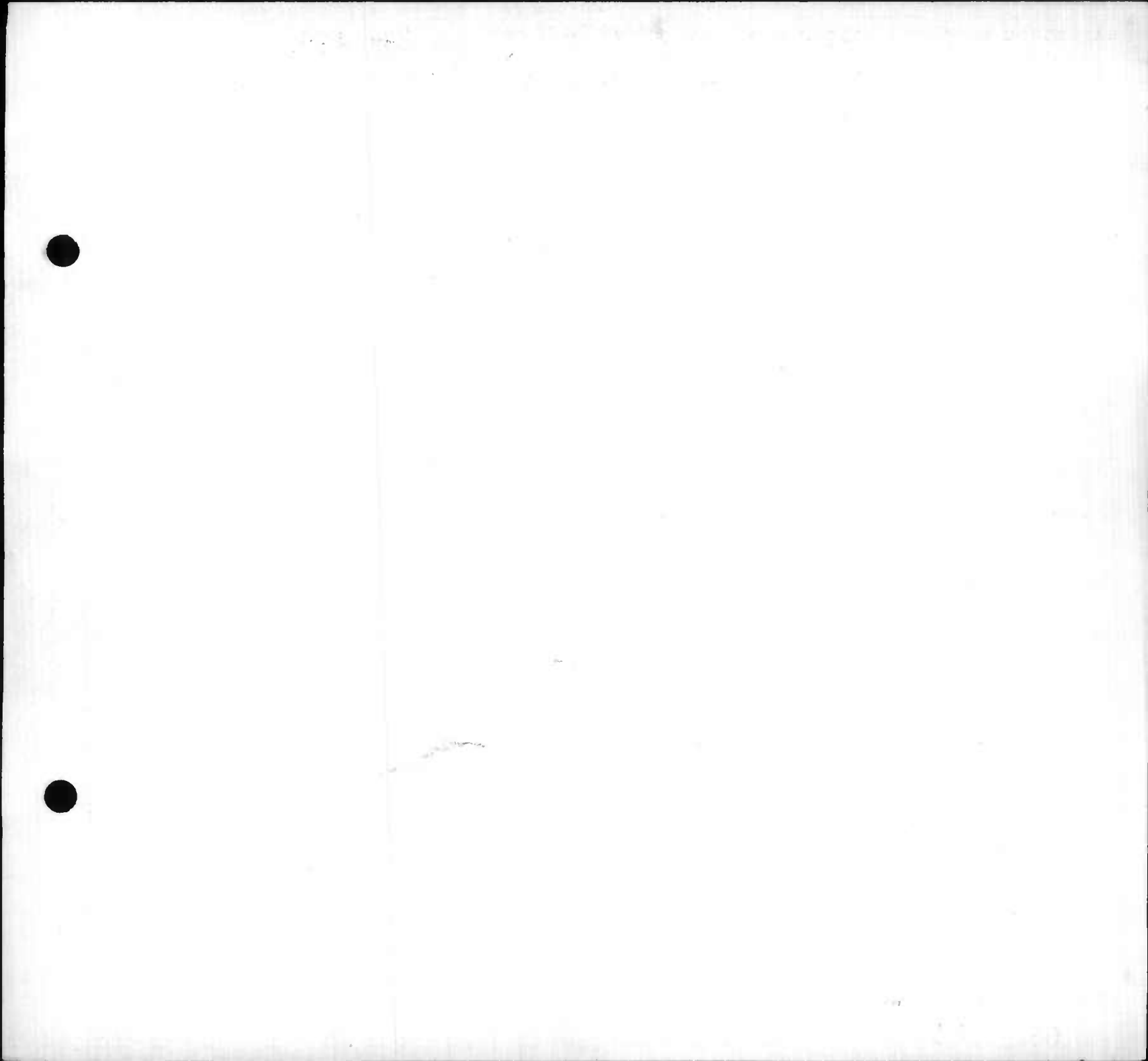
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		72 11698		REG. NO.		STATE OF MARYLAND-DEPT	
1. NAME OF DECEASED (Type or Print) <b>MORGAN, Mrs. CARLYN A.</b>				2. DATE AND HOUR OF DEATH <b>12/8/72 6:30 A.M.</b>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>CHURCH HOME &amp; HOSPITAL 100N. BROAD WAY BALTIMORE MD</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>21205</b>				602	
				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER <b>2705 JEFFERSON ST.</b>					
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-10-04</b>		9. AGE (In years last birthday) <b>68</b>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>AMER</b>			
13. FATHER'S NAME <b>JAMES BRENCE</b>				14. MOTHER'S MAIDEN NAME <b>PEARL E. ANDREWS</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220204807</b>		17. INFORMANT <b>EDWARD SMITH</b>		ADDRESS <b>2705 JEFFERSON ST</b>			
18. <b>208X1</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <b>Cardio pulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Congestive Heart Failure</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 min</b>	
				(B) <b>ASWD. COPD</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Several yrs.</b>				<b>10 days.</b>	
				(C) <b>Poly cythemia</b>				<b>10 ?</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>11/23/1972</b> to <b>12/8/1972</b> that (I) (we) last saw the deceased alive on <b>12/8/1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>L. Padmaraju M.D.</b>				23B. DATE SIGNED <b>12/8/72</b>		23C. PHYSICIAN'S NAME (Type) <b>L. PADMARAJU, M.D.</b>			
23D. ADDRESS <b>2334 Jefferson St.</b>									
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12-11-72</b>		24C. NAME of CEMETERY or CREMATORY <b>CREST LAWN CEM.</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO., Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 8 1972</b>		25B. NAME OF REGISTRAR <b>Tridney Johnston</b>		25C. FUNERAL DIRECTOR <b>John A. Miller</b>		ADDRESS <b>2334 Jefferson St.</b>			

*Chlorophyllum nigrum*

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 11699		BALTIMORE CITY HEALTH DEPARTMENT		72 11699	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>ELLEN TERRY</b>		2. DATE AND HOUR OF DEATH <b>12/7/72 7:25 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIVERSITY OF MARYLAND HOSPITAL</b>		A. STATE <b>MD</b>		B. COUNTY <b>1801</b>	
		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>940 W. FRANKLIN ST</b>			
5. SEX <b>FF</b>	6. RACE <b>B</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-8-19</b>	9. AGE (In years last birthday) <b>-53</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
13. FATHER'S NAME <b>??</b>		12. CITIZEN OF WHAT COUNTRY <b>U S A</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME <b>EDNA JONES</b>			
		17. INFORMANT <b>Chart</b>			
18. <b>150X I</b>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <b>ASPIRATION PNEUMONIA</b> DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>CARCINOMA OF ESOPHAGUS</b> DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>11/13</b> 19 <b>72</b> to <b>12/7</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>12/7</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Thomas E. Murphy MD</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>12/7/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Thomas E. Murphy MD</b>		23D. ADDRESS <b>UNIVERSITY HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/11/72</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt Calvary Cemetry</b>	
		24D. LOCATION <b>A A County Md</b>		(City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 8 1972</b>		25B. NAME OF REGISTRAR <b>Adolphus Halstead</b>		25C. FUNERAL DIRECTOR <b>Adolphus Halstead</b>	
				ADDRESS <b>1206 W north Ave</b>	





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 11700

BIRTH NO.

STATE OF MARYLAND-DMH

1. NAME OF DECEASED (Type or Print) <b>Muriel Hilton</b>				2. DATE Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 12 8 72 2:30 P. M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1645 N. Ellamont</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour 12 8 72 2:30 P. M.			
6. SEX Female				7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 12/21/21				10. AGE (In years lost birthday) 50 51		11. BIRTHPLACE (State or foreign country) Baltimore, Md	
12. CITIZEN OF WHAT COUNTRY? U S A				13. FATHER'S NAME Thomas Jackson			
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				15. MOTHER'S MAIDEN NAME Mary			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS Husband, same	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE Atherosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>W P Mulloy</i> M.D. EXAMINER'S NAME (Type) William P. Mulloy, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12-9-72							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/11/72		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md	
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1972		25B. NAME OF REGISTRAR Sidney Johnston		25C. FUNERAL DIRECTOR Adolphus Halstead		ADDRESS 1206 W North Ave	

DEPT OF AGRICULTURE

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

1914

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

26

27

28

29

30

31

32

33

34

35

36

37

38

39

40

41

42

43

44

45

46

47

48

49

50

51

52

53

54

55

56

57

58

59

60

61

62

63

64

65

66

67

68

69

70

71

72

73

74

75

76

77

78

79

80

81

82

83

84

85

86

87

88

89

90

91

92

93

94

95

96

97

98

99

100

101

102

103

104

105

106

107

108

109

110

111

112

113

114

115

116

117

118

119

120

121

122

123

124

125

126

127

128

129

130

131

132

133

134

135

136

137

138

139

140

141

142

143

144

145

146

147

148

149

150

151

152

153

154

155

156

157

158

159

160

161

162

163

164

165

166

167

168

169

170

171

172

173

174

175

176

177

178

179

180

181

182

183

184

185

186

187

188

189

190

191

192

193

194

195

196

197

198

199

200

201

202

203

204

205

206

207

208

209

210

211

212

213

214

215

216

217

218

219

220

221

222

223

224

225

226

227

228

229

230

231

232

233

234

235

236

237

238

239

240

241

242

243

244

245

246

247

248

249

250

251

252

253

254

255

256

257

258

259

260

261

262

263

264

265

266

267

268

269

270

271

272

273

274

275

276

277

278

279

280

281

282

283

284

285

286

287

288

289

290

291

292

293

294

295

296

297

298

299

300

301

302

303

304

305

306

307

308

309

310

311

312

313

314

315

316

317

318

319

320

321

322

323

324

325

326

327

328

329

330

331

332

333

334

335

336

337

338

339

340

341

342

343

344

345

346

347

348

349

350

351

352

353

354

355

356

357

358

359

360

361

362

363

364

365

366

367

368

369

370

371

372

373

374

375

376

377

378

379

380

381

382

383

384

385

386

387

388

389

390

391

392

393

394

395

396

397

398

399

400

401

402

403

404

405

406

407

408

409

410

411

412

413

414

415

416

417

418

419

420

421

422

423

424

425

426

427

428

429

430

431

432

433

434

435

436

437

438

439

440

441

442

443

444

445

446

447

448

449

450

451

452

453

454

455

456

457

458

459

460

461

462

463

464

465

466

467

468

469

470

471

472

473

474

475

476

477

478

479

480

481

482

483

484

485

486

487

488

489

490

491

492

493

494

495

496

497

498

499

500

501

502

503

504

505

506

507

508

509

510

511

512

513

514

515

516

517

518

519

520

521

522

523

524

525

526

527

528

529

530

531

532

533

534

535

536

537

538

539

540

541

542

543

544

545

546

547

548

549

550

551

552

553

554

555

556

557

558

559

560

561

562

563

564

565

566

567

568

569

570

571

572

573

574

575

576

577

578

579

580

581

582

583

584

585

586

587

588

589

590

591

592

593

594

595

596

597

598

599

600

601

602

603

604

605

606

607

608

609

610

611

612

613

614

615

616

617

618

619

620

621

622

623

624

625

626

627

628

629

630

631

632

633

634

635

636

637

638

639

640

641

642

643

644

645

646

647

648

649

650

651

652

653

654

655

656

657

658

659

660

661

662

663

664

665

666

667

668

669

670

671

672

673

674

675

676

677

678

679

680

681

682

683

684

685

686

687

688

689

690

691

692

693

694

695

696

697

698

699

700

701

702

703

704

705

706

707

708

709

710

711

712

713

714

715

716

717

718

719

720

721

722

723

724

725

726

727

728

729

730

731

732

733

734

735

736

737

738

739

740

741

742

743

744

745

746

747

748

749

750

751

752

753

754

755

756

757

758

759

760

761

762

763

764

765

766

767

768

769

770

771

772

773

774

775

776

777

778

779

780

781

782

783

784

785

786

787

788

789

790

791

792

793

794

795

796

797

798

799

800

801

802

803

804

805

806

807

808

809

810

811

812

813

814

815

816

817

818

819

820

821

822

823

824

825

826

827

828

829

830

831

832

833

834

835

836

837

838

839

840

841

842

843

844

845

846

847

848

849

850

851

852

853

854

855

856

857

858

859

860

861

862

863

864

865

866

867

868

869

870

871

872

873

874

875

876

877

878

879

880

881

882

883

884

885

886

887

888

889

890

891

892

893

894

895

896

897

898

899

900

901

902

903

904

905

906

907

908

909

910

911

912

913

914

915

916

917

918

919

920

921

922

923

924

925

926

927

928

929

930

931

932

933

934

935

936

937

938

939

940

941

942

943

944

945

946

947

948

949

950

951

952

953

954

955

956

957

958

959

960

961

962

963

964

965

966

967

968

969

970

971

972

973

974

975

976

977

978

979

980

981

982

983

984

985

986

987

988

989

990

991

992

993

994

995

996

997

998

999

1000

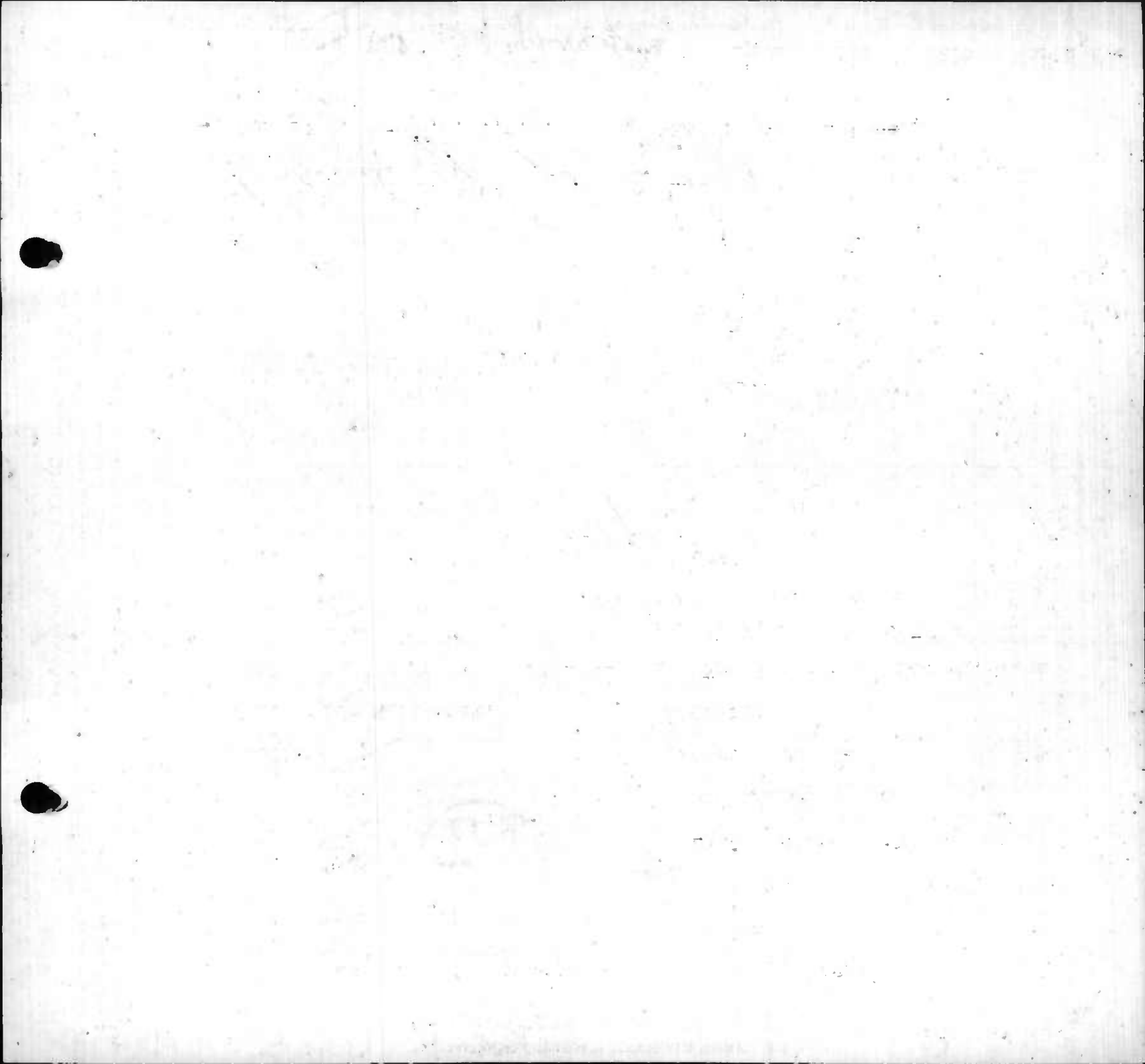
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
72 11701 CERTIFICATE OF DEATH

REG. NO. 72 11701

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Theophilus H Stewart		12/8/72	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
2326 Madison Ave				Maryland	
				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
				Baltimore YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER	
				2326 Madison Ave	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)
M	B	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	6/26/1900		72
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
Retired					Petersburg Va
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Theophilus H Stewart			Elizabeth		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
		213-09-4661		Mrs Estella C Stewart, Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		ARTERIOSCLEROTIC CARDIAC DISEASE		10 yrs.	
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		over 10 yrs.	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Hypertension			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 10-30-69 to 12-8-72, that (1) (we) last saw the deceased alive on 10-26-72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Richard F. Tyson, M.D., P.A.				12/8/72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Richard F. Tyson, M.D., P.A.				936 W. North Avenue	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
24D. LOCATION (City, town, or county)		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
DEC 8 1972		Adolphus Halstead		1206 W North Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 11702		72 11702	
CERTIFICATE OF DEATH				STATE OF MARYLAND-DEMH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
		HOLLEY, LUCILLE		12/6/72		1 3,50 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
SINAI HOSPITAL OF BALTIMORE 42				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER PARK HEIGHTS AVE			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years lost birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		
FEMALE	NEGRO		11/20/20	52	Nurses Aid		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
		Hospital		Baltimore, Maryland		U.S.A.	
13. FATHER'S NAME Winston Kirkley				14. MOTHER'S MAIDEN NAME Alice Bond			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
		214-12-9103		Mrs Alice Kirkley, 1321		Warden S.	
18. 436.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
<p>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		4 days	
				(B) SEVERE HYPERTENSION DUE TO, OR AS A CONSEQUENCE OF:			
				(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				GENERAL- ARTERIOSCLEROSIS.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12/2/1972 to 12/6/1972 that (I) (we) last saw the deceased alive on 12/6/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Hickos, MD.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12/6/72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
A. MIHAS, MD				SINAI HOSPITAL OF BALTIMORE			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		12/13/72		MT Auburn Cemetery		Baltimore, M	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
DEC 8 1972		Adolphus		Halstead 1206 W north Ave			

4307 PARK HEIGHTS

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 11703

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Philip - PHILLIP GILLIAM

2. DATE

Known ☒ Estimated ☐

Month

Day

Year

Hour

DEATH

December 7, 1972

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(If not in hospital or institution, give street  
address or location)

1545 Ensor Street

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

December 7, 1972

9:16 A.

M.

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

Maryland

B. COUNTY

909

6. SEX

Male

7. RACE

Negro

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

9-1-1911

10. AGE (In years  
lost birthday)

61

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

1545 Ensor Street

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Acy Gilliam

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer

14B. KIND OF BUSINESS OR INDUSTRY

Steel Co

15. MOTHER'S MAIDEN NAME

REBECCA REDD

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

17. SOCIAL  
SECURITY NO.

215-16-9649

18. INFORMANT

ADDRESS

Mrs. Nonie Bell Gilliam 1545 N. Ensor St.

19. 412.4

CAUSE OF DEATH

Arteriosclerotic cardiovascular disease

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Marvin S. Platt, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

December 7, 1972

24A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

24B. DATE

12-11-72

24C. NAME OF CEMETERY OR CREMATORY

BALTIMORE CEMETERY

24D. LOCATION (City, town, or county)

BALTIMORE,

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT

DEC 8 1972

25B. NAME OF REGISTRAR

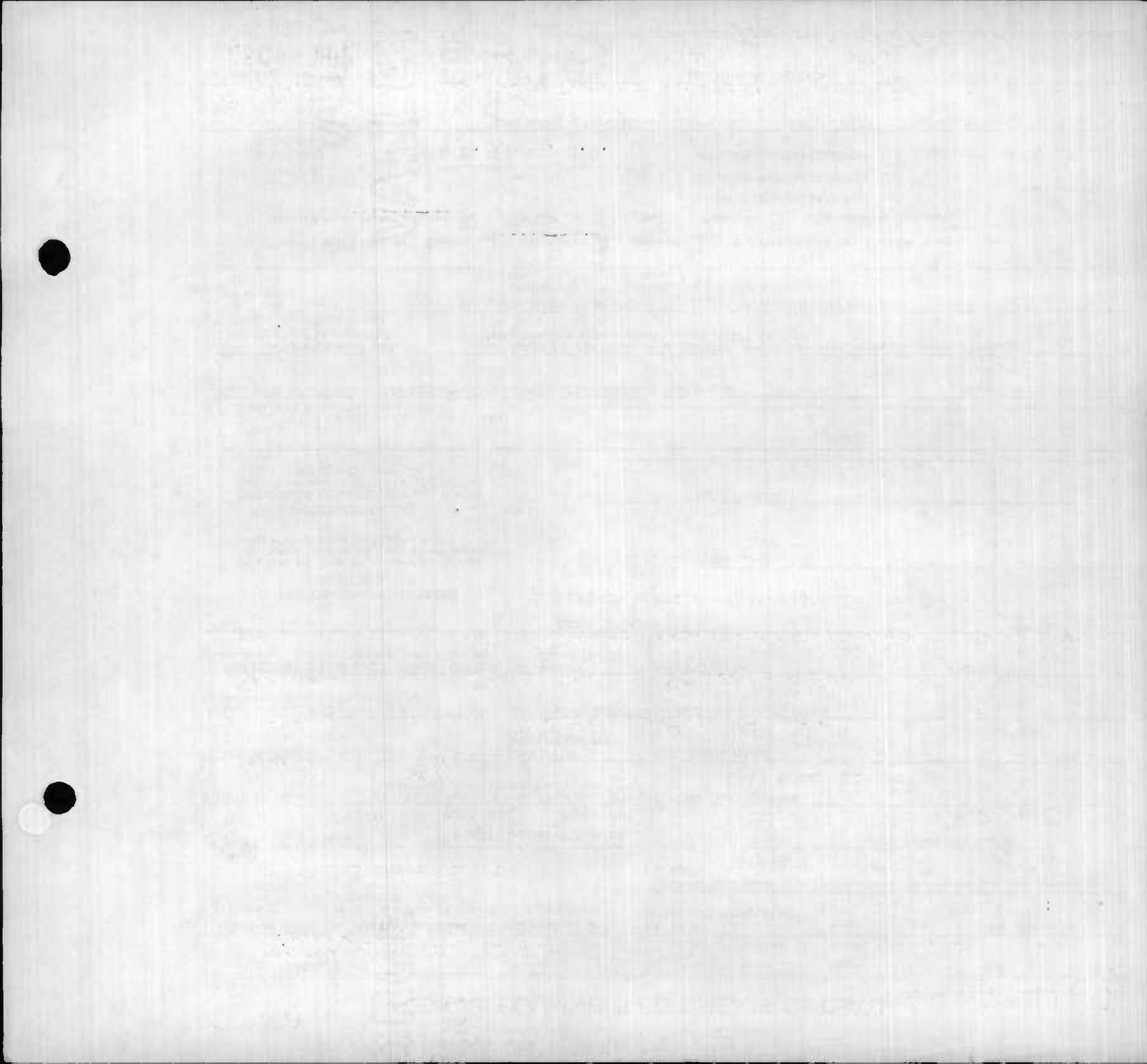
Sidney Whitson

25C. FUNERAL DIRECTOR

Randolph J. Collick 2431 E. Oliver St.

ADDRESS





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 11704		REG. NO. 72 11704	
W-425				72 11704		STATE OF MARYLAND-DIVISION	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>JAMES E. WILKENS</b>				2. DATE AND HOUR OF DEATH <b>12/6/72 9:20 P</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>600 Liberty Height Ave. Baltimore, Md. 21215 President Hospital Inc.</b>				A. STATE <b>Maryland</b> B. COUNTY <b>1607</b>			
5. SEX <b>M</b>				6. RACE <b>B</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Grocery Store</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>	
13. FATHER'S NAME <b>John T. Wilkins</b>				14. MOTHER'S MAIDEN NAME <b>Minnie Silver</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Minnie Fair</b>	
18. <b>485X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Diffuse Bunchopneumonia and Multiple lung Abscesses with Pyrexemia</b>				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>2</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nasty medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>10/31</b> 19 <b>72</b> to <b>12/6</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>12/6/72</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Virginia F. Mercado, M.D.</b>				23B. DATE SIGNED <b>12/6/72</b>		23C. PHYSICIAN'S NAME (Type) <b>VIRGINIA F. MERCADO, M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>12-10-72</b>		24C. NAME of CEMETERY or CREMATORY <b>Wilkins + Ward</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 8 1972</b>				25B. NAME OF REGISTRAR <b>Adrian Houston</b>		25C. FUNERAL DIRECTOR <b>GEO. Q. Kelson</b>	
24D. LOCATION (City, town, or county) (State) <b>Field North Carolina</b>				24E. ADDRESS <b>1348 N. Calhoun St.</b>			

Handwritten text at the top of the page, mostly illegible due to fading and bleed-through. Some words like "M. 241-6012" are visible.

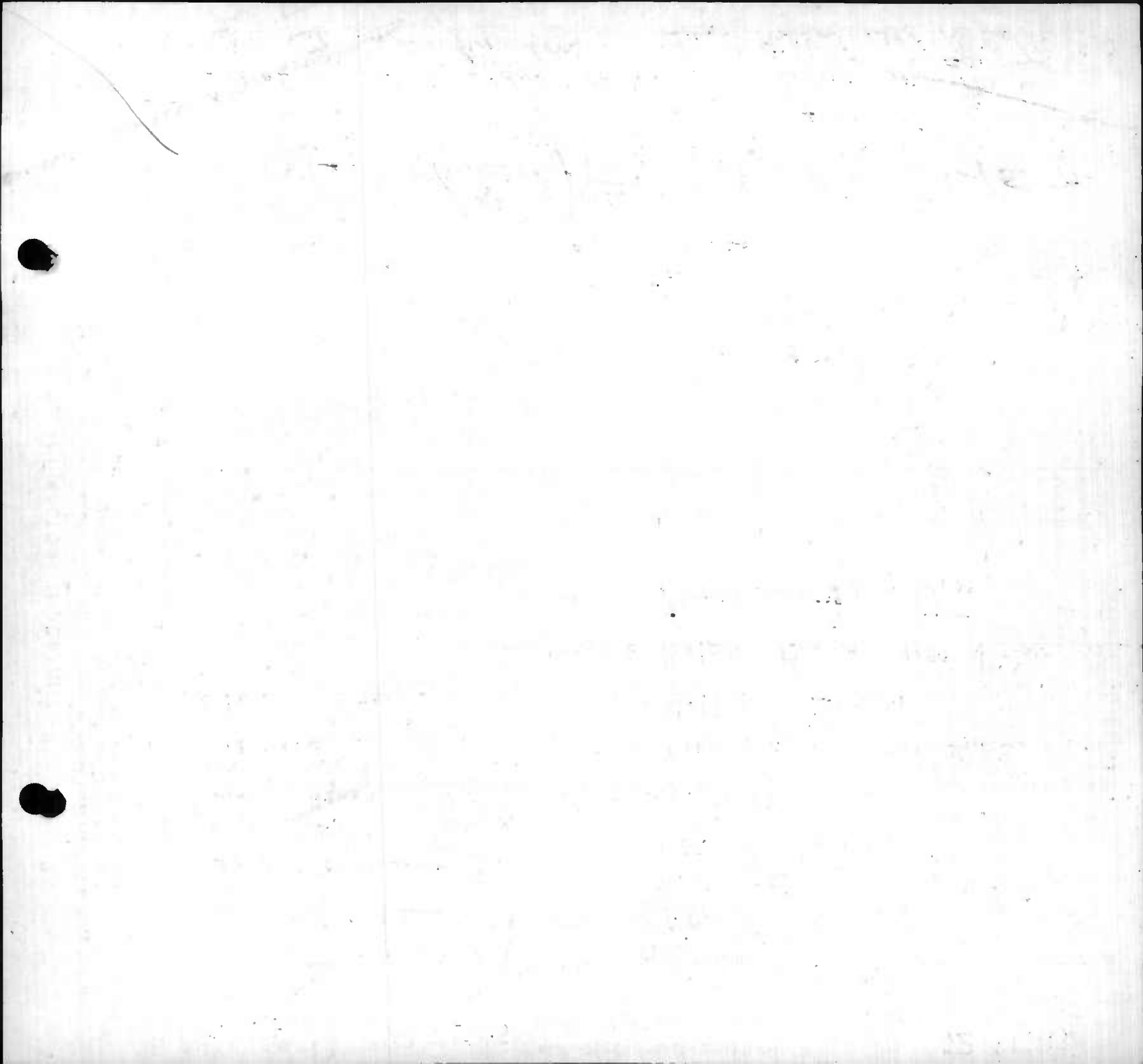
Handwritten text in the lower middle section of the page, appearing as bleed-through from the reverse side. Some words like "M. 241-6012" are visible.

Handwritten text at the bottom of the page, appearing as bleed-through from the reverse side.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 11705		REG. NO. 72 11705	
P-265				72 11705			
BIRTH NO.				STATE OF MARYLAND-DEATH			
1. NAME OF DECEASED (Type or Print) <u>Ruth Pegram</u>				2. DATE AND HOUR OF DEATH <u>12-2-72</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>1159 N. Calhoun St.</u>				A. STATE <u>Md.</u>		B. COUNTY <u>1602</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>Female</u>				6. RACE <u>NEGRO</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>Sept. 13, 1899</u>				9. AGE (In years last birthday) <u>73</u>		10. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>Ellis Shands</u>				14. MOTHER'S MAIDEN NAME <u>Nellie Brown</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>213-74-1736</u>		17. INFORMANT <u>Ralph Pegram</u>	
18. <u>410.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Myocardial Infarction</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examined)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Oct 6, 1972</u> to <u>11/22, 1972</u> , that (I) (we) last saw the deceased alive on <u>11/22, 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Archie Johnson M.D.</u>						23B. DATE SIGNED <u>12/5/72</u>	
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>						24B. DATE <u>12-5-72</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>						24D. LOCATION (City, town, or county) (State) <u>Brooklyn Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 8 1972</u>						25B. NAME OF REGISTRAR <u>Sidney Winston</u>	
25C. FUNERAL DIRECTOR <u>Lee H. Kelson</u>						25D. ADDRESS <u>1348 N. Calhoun St.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72 11706</u> <u>STATE OF MARYLAND - BALTIMORE</u>
<u>W-300</u> BIRTH NO. <u>72 11706</u> 1. NAME OF DECEASED (Type or Print) <u>White Harry</u>		2. DATE AND HOUR OF DEATH <u>12-7-72</u> <u>5:30 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Duke Land Nursing Home 1501 N. Duke Land St.</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1506</u> C. CITY OR TOWN <u>BALTO</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1605 Bloomingdale Rd</u>		
5. SEX <u>M</u>	6. RACE <u>N N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-20-18</u>	9. AGE (In years last birthday) <u>54</u> If Under 1 Yr. Months Days If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Duke Land Nursing Home</u> ADDRESS <u>1501 N. Duke Land St.</u>
18. <u>436.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>CVA</u> DUE TO, OR AS A CONSEQUENCE OF:  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>10-25-1972</u> to <u>12-7-1972</u> that (I) (we) lost saw the deceased alive on <u>12-6-1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Perceval C. Smith</u> DEGREE			23B. DATE SIGNED <u>12-7-72</u> Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>12-11-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Auburn</u>
24D. LOCATION (City, town, or county) <u>Westport</u>		24E. STATE (State)		
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 8 1972</u>		25B. NAME OF REGISTRAR <u>Edw. J. Houston</u>		25C. FUNERAL DIRECTOR <u>Geo. G. Kelsch</u> ADDRESS <u>1348 N. Calhoun</u>

17-11-57 Mr. Herbert  
100-5-1079 12984 6/10/1957



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 11707	
BIRTH NO. 72 11707				STATE OF MARYLAND - DEATH	
1. NAME OF DECEASED (Type or Print) <b>TEOFILA BALAKIER</b>			2. DATE AND HOUR OF DEATH <b>DEC. 6, 1972</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>00 741 SOUTH MONTFORD AVE</b>			A. STATE <b>MARYLAND</b> B. COUNTY <b>103</b>		
			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>741 S. MONTFORD AVE</b>		
5. SEX <b>F.</b>	6. RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT. 7, 1890</b>	9. AGE (In years last birthday) <b>82 yrs.</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>POLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Francis LACHOWSKA</b>		
14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		
16. SOCIAL SECURITY NO.			17. INFORMANT <b>MRS. EDWINA BYRNES 741 S. MONTFORD AVE</b>		
18. <b>4123 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CEREBRAL VASCULAR Accident 3 days</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arteriosclerotic heart disease 20 years?</b>					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>2/1/71</b> 19 to <b>12/6/72</b> 19, that (I) ( <del>was</del> ) last saw the deceased alive on <b>12/6/72</b> 19 and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes noted above. (I) ( <del>was</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <b>Max Bauman M.D.</b>				23B. DATE SIGNED <b>11/8/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>MAX BAUM M.D.</b>				23D. ADDRESS <b>7422 EASTERN AVE</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12/11/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Holy Rosary Cemetery Baltimore MD.</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore MD.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 8 1972</b>		25B. NAME OF REGISTRAR <b>Sidney W. ...</b>	
		25C. FUNERAL DIRECTOR <b>Raymond L. Kaczorowski</b>		ADDRESS <b>2525 Fleet St.</b>	

CHIEF OF POLICE DEPT. OF NEW YORK

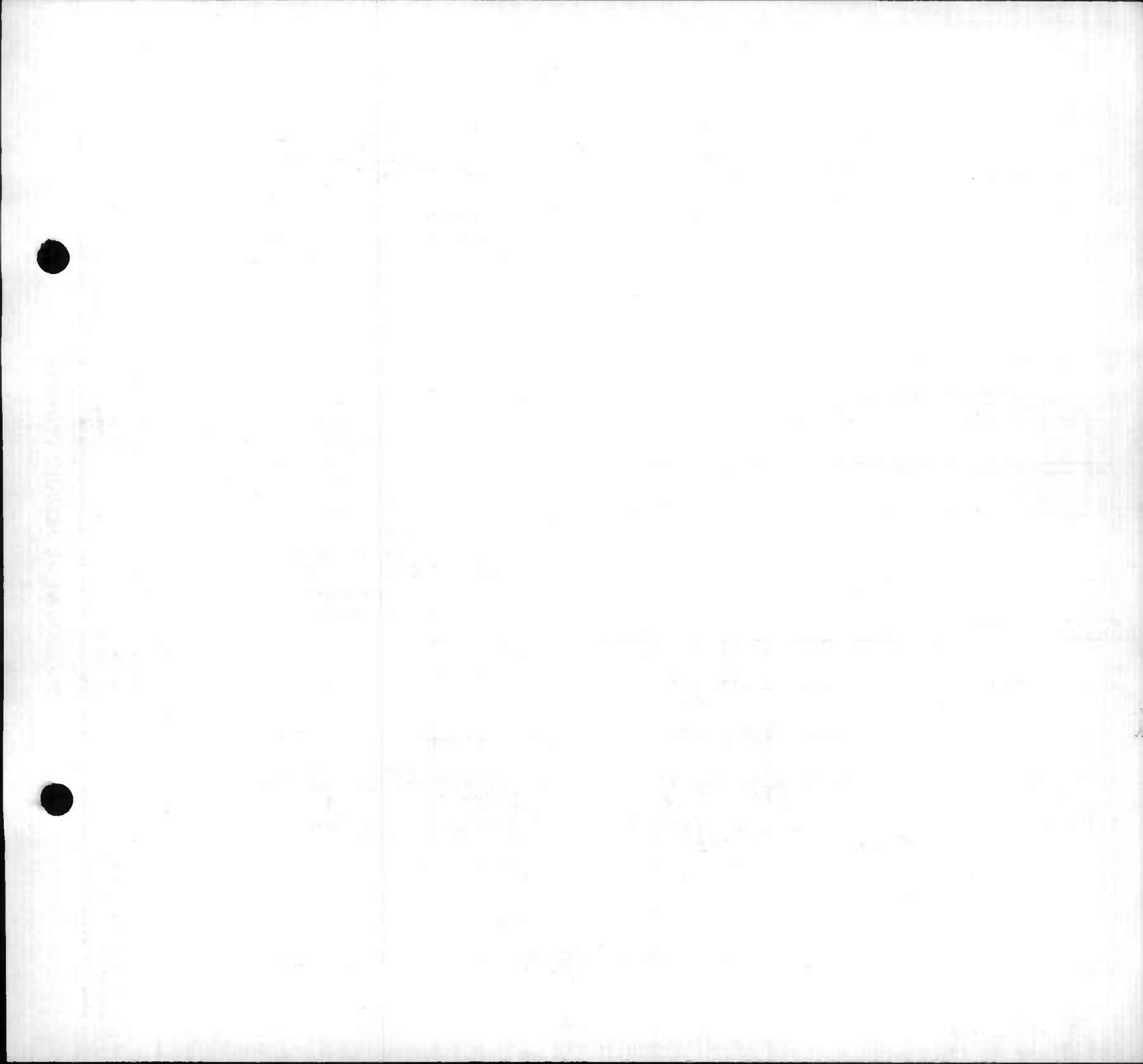
RECEIVED BY THE CHIEF OF POLICE

NEW YORK, N. Y.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

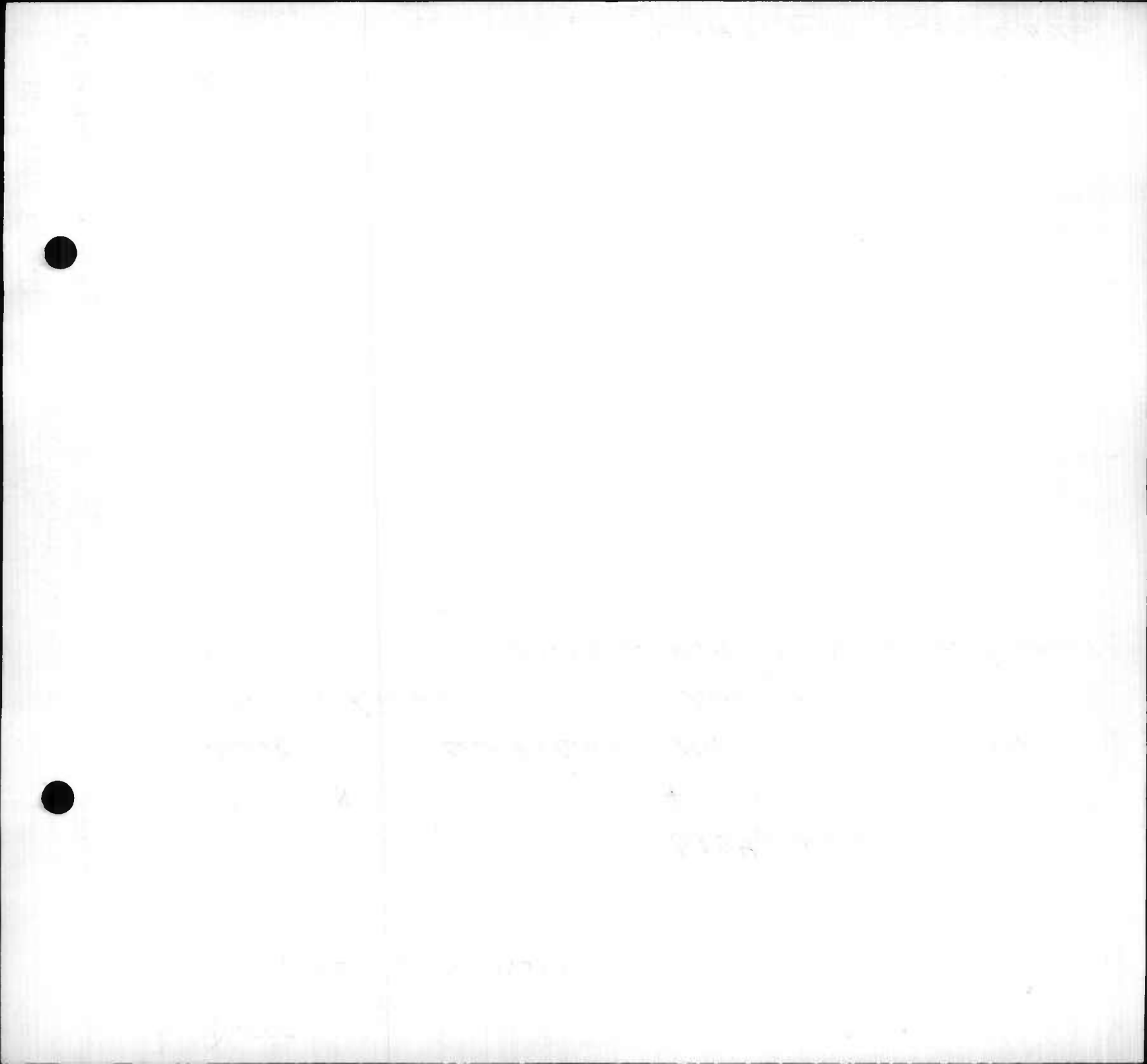
BALTIMORE CITY HEALTH DEPARTMENT				72 11708	
C-636				72 11708	
BIRTH NO.				72 11708	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH	
Charter Michael				12-5-1972 3:10 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
Maryland General Hospital				Maryland	
48				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
Baltimore				YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER				1716 Eutaw Place	
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
M		N		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH		9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
5-22-1889		83		Presser	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
Washington, D.C.		USA		John Charter	
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
Mary		NO		215 07 9128A	
17. INFORMANT		ADDRESS		18. CAUSE OF DEATH	
Hattie Charter		1716 Eutaw Place		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Pneumonia	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:		ANTECEDENT CAUSES	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		MEDICAL CERTIFICATION	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Approx.)		21E. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-27 1972 to 12-5 1972		that (I) (we) last saw the deceased alive on 12-5 1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE	
A. J. Segueira		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		12-5-1972	
A. J. Segueira		Maryland General Hospital		24A. BURIAL CREMATION, REMOVAL (Specify)	
Burial		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
12/9/72		Mt. Auburn		24D. LOCATION (City, town, or county) (State)	
Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT		25B. NAME OF REGISTRAR	
DEC 8 1972		Herbert E. Nutter		25C. FUNERAL DIRECTOR	
3035 W. North Ave		ADDRESS		VS 150-REV. 1/1/68	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="float: right;">72 11709</span>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <span style="float: right;">72 11709</span>
1. NAME OF DECEASED (Type or Print) <b>DEWEY EDGAR DUNSON</b>		2. DATE AND HOUR OF DEATH <b>12-7-72 12-15 AM</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Lutheran Hospital of Maryland</b>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>BALTIMORE</b> B. COUNTY <b>MARYLAND</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>6734 Brookmont Dr 21207</b>		
5. SEX <b>M</b>	6. RACE <b>N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-9-99</b>	9. AGE (In years last birthday) <b>73 yr</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PAINTER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>SELF EMPLOYED</b>		11. BIRTHPLACE (State or foreign country) <b>MD.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Thornton Dunson</b>		
14. MOTHER'S MAIDEN NAME <b>Grace Johns</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>21901 3028A</b>		17. INFORMANT <b>Mollie E. Dunson 6734 Brookmont Dr.</b>		
18. <b>486X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Pneumonia</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Pneumonia</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Pachymyositis Disease</b>		?		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>—</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>—</b>
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>—</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>—</b>
22. I certify that (X) (this hospital) attended the deceased from <b>12-2-72</b> to <b>12-7-72</b> that (X) (we) last saw the deceased alive on <b>12-7-72</b> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>C. A. Mue</b>		23B. DATE SIGNED <b>12/7/72</b>		23C. PHYSICIAN'S NAME (Type) <b>M. A. ANWAR</b>
23D. ADDRESS <b>Lutheran Hospital of Maryland</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		
24B. DATE <b>12/11/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Co., Md</b>
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 8 1972</b>		25B. NAME OF REGISTRAR <b>Arbutus Memorial Park</b>		25C. FUNERAL DIRECTOR <b>Robert E. Butler 3035 W North Ave.</b>



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 11710	
M-248 72 11710				STATE OF MARYLAND-DHMH	
BIRTH NO.			BIRTH NO.		
1. NAME OF DECEASED (Type or Print) <b>Micheal, Audrey Lorraine Lee</b>			2. DATE AND HOUR OF DEATH <b>December 7, 1972 10:45 pm</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Provident Hospital, Inc. 2600 Liberty Height Ave. Baltimore, Md. 21215</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1601</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>629 Carrollton Ave.</b>		
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-30-34</b>		9. AGE (In years lost <sup>1</sup> / <sub>2</sub> - 1 <sup>1</sup> / <sub>2</sub> - 2 <sup>1</sup> / <sub>2</sub> - 3 <sup>1</sup> / <sub>2</sub> - 4 <sup>1</sup> / <sub>2</sub> - 5 <sup>1</sup> / <sub>2</sub> - 6 <sup>1</sup> / <sub>2</sub> - 7 <sup>1</sup> / <sub>2</sub> - 8 <sup>1</sup> / <sub>2</sub> - 9 <sup>1</sup> / <sub>2</sub> - 10 <sup>1</sup> / <sub>2</sub> - 11 <sup>1</sup> / <sub>2</sub> - 12 <sup>1</sup> / <sub>2</sub> - 13 <sup>1</sup> / <sub>2</sub> - 14 <sup>1</sup> / <sub>2</sub> - 15 <sup>1</sup> / <sub>2</sub> - 16 <sup>1</sup> / <sub>2</sub> - 17 <sup>1</sup> / <sub>2</sub> - 18 <sup>1</sup> / <sub>2</sub> - 19 <sup>1</sup> / <sub>2</sub> - 20 <sup>1</sup> / <sub>2</sub> - 21 <sup>1</sup> / <sub>2</sub> - 22 <sup>1</sup> / <sub>2</sub> - 23 <sup>1</sup> / <sub>2</sub> - 24 <sup>1</sup> / <sub>2</sub> - 25 <sup>1</sup> / <sub>2</sub> - 26 <sup>1</sup> / <sub>2</sub> - 27 <sup>1</sup> / <sub>2</sub> - 28 <sup>1</sup> / <sub>2</sub> - 29 <sup>1</sup> / <sub>2</sub> - 30 <sup>1</sup> / <sub>2</sub> - 31 <sup>1</sup> / <sub>2</sub> - 32 <sup>1</sup> / <sub>2</sub> - 33 <sup>1</sup> / <sub>2</sub> - 34 <sup>1</sup> / <sub>2</sub> - 35 <sup>1</sup> / <sub>2</sub> - 36 <sup>1</sup> / <sub>2</sub> - 37 <sup>1</sup> / <sub>2</sub> - 38 <sup>1</sup> / <sub>2</sub> - 39 <sup>1</sup> / <sub>2</sub> - 40 <sup>1</sup> / <sub>2</sub> - 41 <sup>1</sup> / <sub>2</sub> - 42 <sup>1</sup> / <sub>2</sub> - 43 <sup>1</sup> / <sub>2</sub> - 44 <sup>1</sup> / <sub>2</sub> - 45 <sup>1</sup> / <sub>2</sub> - 46 <sup>1</sup> / <sub>2</sub> - 47 <sup>1</sup> / <sub>2</sub> - 48 <sup>1</sup> / <sub>2</sub> - 49 <sup>1</sup> / <sub>2</sub> - 50 <sup>1</sup> / <sub>2</sub> - 51 <sup>1</sup> / <sub>2</sub> - 52 <sup>1</sup> / <sub>2</sub> - 53 <sup>1</sup> / <sub>2</sub> - 54 <sup>1</sup> / <sub>2</sub> - 55 <sup>1</sup> / <sub>2</sub> - 56 <sup>1</sup> / <sub>2</sub> - 57 <sup>1</sup> / <sub>2</sub> - 58 <sup>1</sup> / <sub>2</sub> - 59 <sup>1</sup> / <sub>2</sub> - 60 <sup>1</sup> / <sub>2</sub> - 61 <sup>1</sup> / <sub>2</sub> - 62 <sup>1</sup> / <sub>2</sub> - 63 <sup>1</sup> / <sub>2</sub> - 64 <sup>1</sup> / <sub>2</sub> - 65 <sup>1</sup> / <sub>2</sub> - 66 <sup>1</sup> / <sub>2</sub> - 67 <sup>1</sup> / <sub>2</sub> - 68 <sup>1</sup> / <sub>2</sub> - 69 <sup>1</sup> / <sub>2</sub> - 70 <sup>1</sup> / <sub>2</sub> - 71 <sup>1</sup> / <sub>2</sub> - 72 <sup>1</sup> / <sub>2</sub> - 73 <sup>1</sup> / <sub>2</sub> - 74 <sup>1</sup> / <sub>2</sub> - 75 <sup>1</sup> / <sub>2</sub> - 76 <sup>1</sup> / <sub>2</sub> - 77 <sup>1</sup> / <sub>2</sub> - 78 <sup>1</sup> / <sub>2</sub> - 79 <sup>1</sup> / <sub>2</sub> - 80 <sup>1</sup> / <sub>2</sub> - 81 <sup>1</sup> / <sub>2</sub> - 82 <sup>1</sup> / <sub>2</sub> - 83 <sup>1</sup> / <sub>2</sub> - 84 <sup>1</sup> / <sub>2</sub> - 85 <sup>1</sup> / <sub>2</sub> - 86 <sup>1</sup> / <sub>2</sub> - 87 <sup>1</sup> / <sub>2</sub> - 88 <sup>1</sup> / <sub>2</sub> - 89 <sup>1</sup> / <sub>2</sub> - 90 <sup>1</sup> / <sub>2</sub> - 91 <sup>1</sup> / <sub>2</sub> - 92 <sup>1</sup> / <sub>2</sub> - 93 <sup>1</sup> / <sub>2</sub> - 94 <sup>1</sup> / <sub>2</sub> - 95 <sup>1</sup> / <sub>2</sub> - 96 <sup>1</sup> / <sub>2</sub> - 97 <sup>1</sup> / <sub>2</sub> - 98 <sup>1</sup> / <sub>2</sub> - 99 <sup>1</sup> / <sub>2</sub> - 100 <sup>1</sup> / <sub>2</sub> - 101 <sup>1</sup> / <sub>2</sub> - 102 <sup>1</sup> / <sub>2</sub> - 103 <sup>1</sup> / <sub>2</sub> - 104 <sup>1</sup> / <sub>2</sub> - 105 <sup>1</sup> / <sub>2</sub> - 106 <sup>1</sup> / <sub>2</sub> - 107 <sup>1</sup> / <sub>2</sub> - 108 <sup>1</sup> / <sub>2</sub> - 109 <sup>1</sup> / <sub>2</sub> - 110 <sup>1</sup> / <sub>2</sub> - 111 <sup>1</sup> / <sub>2</sub> - 112 <sup>1</sup> / <sub>2</sub> - 113 <sup>1</sup> / <sub>2</sub> - 114 <sup>1</sup> / <sub>2</sub> - 115 <sup>1</sup> / <sub>2</sub> - 116 <sup>1</sup> / <sub>2</sub> - 117 <sup>1</sup> / <sub>2</sub> - 118 <sup>1</sup> / <sub>2</sub> - 119 <sup>1</sup> / <sub>2</sub> - 120 <sup>1</sup> / <sub>2</sub> - 121 <sup>1</sup> / <sub>2</sub> - 122 <sup>1</sup> / <sub>2</sub> - 123 <sup>1</sup> / <sub>2</sub> - 124 <sup>1</sup> / <sub>2</sub> - 125 <sup>1</sup> / <sub>2</sub> - 126 <sup>1</sup> / <sub>2</sub> - 127 <sup>1</sup> / <sub>2</sub> - 128 <sup>1</sup> / <sub>2</sub> - 129 <sup>1</sup> / <sub>2</sub> - 130 <sup>1</sup> / <sub>2</sub> - 131 <sup>1</sup> / <sub>2</sub> - 132 <sup>1</sup> / <sub>2</sub> - 133 <sup>1</sup> / <sub>2</sub> - 134 <sup>1</sup> / <sub>2</sub> - 135 <sup>1</sup> / <sub>2</sub> - 136 <sup>1</sup> / <sub>2</sub> - 137 <sup>1</sup> / <sub>2</sub> - 138 <sup>1</sup> / <sub>2</sub> - 139 <sup>1</sup> / <sub>2</sub> - 140 <sup>1</sup> / <sub>2</sub> - 141 <sup>1</sup> / <sub>2</sub> - 142 <sup>1</sup> / <sub>2</sub> - 143 <sup>1</sup> / <sub>2</sub> - 144 <sup>1</sup> / <sub>2</sub> - 145 <sup>1</sup> / <sub>2</sub> - 146 <sup>1</sup> / <sub>2</sub> - 147 <sup>1</sup> / <sub>2</sub> - 148 <sup>1</sup> / <sub>2</sub> - 149 <sup>1</sup> / <sub>2</sub> - 150 <sup>1</sup> / <sub>2</sub> - 151 <sup>1</sup> / <sub>2</sub> - 152 <sup>1</sup> / <sub>2</sub> - 153 <sup>1</sup> / <sub>2</sub> - 154 <sup>1</sup> / <sub>2</sub> - 155 <sup>1</sup> / <sub>2</sub> - 156 <sup>1</sup> / <sub>2</sub> - 157 <sup>1</sup> / <sub>2</sub> - 158 <sup>1</sup> / <sub>2</sub> - 159 <sup>1</sup> / <sub>2</sub> - 160 <sup>1</sup> / <sub>2</sub> - 161 <sup>1</sup> / <sub>2</sub> - 162 <sup>1</sup> / <sub>2</sub> - 163 <sup>1</sup> / <sub>2</sub> - 164 <sup>1</sup> / <sub>2</sub> - 165 <sup>1</sup> / <sub>2</sub> - 166 <sup>1</sup> / <sub>2</sub> - 167 <sup>1</sup> / <sub>2</sub> - 168 <sup>1</sup> / <sub>2</sub> - 169 <sup>1</sup> / <sub>2</sub> - 170 <sup>1</sup> / <sub>2</sub> - 171 <sup>1</sup> / <sub>2</sub> - 172 <sup>1</sup> / <sub>2</sub> - 173 <sup>1</sup> / <sub>2</sub> - 174 <sup>1</sup> / <sub>2</sub> - 175 <sup>1</sup> / <sub>2</sub> - 176 <sup>1</sup> / <sub>2</sub> - 177 <sup>1</sup> / <sub>2</sub> - 178 <sup>1</sup> / <sub>2</sub> - 179 <sup>1</sup> / <sub>2</sub> - 180 <sup>1</sup> / <sub>2</sub> - 181 <sup>1</sup> / <sub>2</sub> - 182 <sup>1</sup> / <sub>2</sub> - 183 <sup>1</sup> / <sub>2</sub> - 184 <sup>1</sup> / <sub>2</sub> - 185 <sup>1</sup> / <sub>2</sub> - 186 <sup>1</sup> / <sub>2</sub> - 187 <sup>1</sup> / <sub>2</sub> - 188 <sup>1</sup> / <sub>2</sub> - 189 <sup>1</sup> / <sub>2</sub> - 190 <sup>1</sup> / <sub>2</sub> - 191 <sup>1</sup> / <sub>2</sub> - 192 <sup>1</sup> / <sub>2</sub> - 193 <sup>1</sup> / <sub>2</sub> - 194 <sup>1</sup> / <sub>2</sub> - 195 <sup>1</sup> / <sub>2</sub> - 196 <sup>1</sup> / <sub>2</sub> - 197 <sup>1</sup> / <sub>2</sub> - 198 <sup>1</sup> / <sub>2</sub> - 199 <sup>1</sup> / <sub>2</sub> - 200 <sup>1</sup> / <sub>2</sub> - 201 <sup>1</sup> / <sub>2</sub> - 202 <sup>1</sup> / <sub>2</sub> - 203 <sup>1</sup> / <sub>2</sub> - 204 <sup>1</sup> / <sub>2</sub> - 205 <sup>1</sup> / <sub>2</sub> - 206 <sup>1</sup> / <sub>2</sub> - 207 <sup>1</sup> / <sub>2</sub> - 208 <sup>1</sup> / <sub>2</sub> - 209 <sup>1</sup> / <sub>2</sub> - 210 <sup>1</sup> / <sub>2</sub> - 211 <sup>1</sup> / <sub>2</sub> - 212 <sup>1</sup> / <sub>2</sub> - 213 <sup>1</sup> / <sub>2</sub> - 214 <sup>1</sup> / <sub>2</sub> - 215 <sup>1</sup> / <sub>2</sub> - 216 <sup>1</sup> / <sub>2</sub> - 217 <sup>1</sup> / <sub>2</sub> - 218 <sup>1</sup> / <sub>2</sub> - 219 <sup>1</sup> / <sub>2</sub> - 220 <sup>1</sup> / <sub>2</sub> - 221 <sup>1</sup> / <sub>2</sub> - 222 <sup>1</sup> / <sub>2</sub> - 223 <sup>1</sup> / <sub>2</sub> - 224 <sup>1</sup> / <sub>2</sub> - 225 <sup>1</sup> / <sub>2</sub> - 226 <sup>1</sup> / <sub>2</sub> - 227 <sup>1</sup> / <sub>2</sub> - 228 <sup>1</sup> / <sub>2</sub> - 229 <sup>1</sup> / <sub>2</sub> - 230 <sup>1</sup> / <sub>2</sub> - 231 <sup>1</sup> / <sub>2</sub> - 232 <sup>1</sup> / <sub>2</sub> - 233 <sup>1</sup> / <sub>2</sub> - 234 <sup>1</sup> / <sub>2</sub> - 235 <sup>1</sup> / <sub>2</sub> - 236 <sup>1</sup> / <sub>2</sub> - 237 <sup>1</sup> / <sub>2</sub> - 238 <sup>1</sup> / <sub>2</sub> - 239 <sup>1</sup> / <sub>2</sub> - 240 <sup>1</sup> / <sub>2</sub> - 241 <sup>1</sup> / <sub>2</sub> - 242 <sup>1</sup> / <sub>2</sub> - 243 <sup>1</sup> / <sub>2</sub> - 244 <sup>1</sup> / <sub>2</sub> - 245 <sup>1</sup> / <sub>2</sub> - 246 <sup>1</sup> / <sub>2</sub> - 247 <sup>1</sup> / <sub>2</sub> - 248 <sup>1</sup> / <sub>2</sub> - 249 <sup>1</sup> / <sub>2</sub> - 250 <sup>1</sup> / <sub>2</sub> - 251 <sup>1</sup> / <sub>2</sub> - 252 <sup>1</sup> / <sub>2</sub> - 253 <sup>1</sup> / <sub>2</sub> - 254 <sup>1</sup> / <sub>2</sub> - 255 <sup>1</sup> / <sub>2</sub> - 256 <sup>1</sup> / <sub>2</sub> - 257 <sup>1</sup> / <sub>2</sub> - 258 <sup>1</sup> / <sub>2</sub> - 259 <sup>1</sup> / <sub>2</sub> - 260 <sup>1</sup> / <sub>2</sub> - 261 <sup>1</sup> / <sub>2</sub> - 262 <sup>1</sup> / <sub>2</sub> - 263 <sup>1</sup> / <sub>2</sub> - 264 <sup>1</sup> / <sub>2</sub> - 265 <sup>1</sup> / <sub>2</sub> - 266 <sup>1</sup> / <sub>2</sub> - 267 <sup>1</sup> / <sub>2</sub> - 268 <sup>1</sup> / <sub>2</sub> - 269 <sup>1</sup> / <sub>2</sub> - 270 <sup>1</sup> / <sub>2</sub> - 271 <sup>1</sup> / <sub>2</sub> - 272 <sup>1</sup> / <sub>2</sub> - 273 <sup>1</sup> / <sub>2</sub> - 274 <sup>1</sup> / <sub>2</sub> - 275 <sup>1</sup> / <sub>2</sub> - 276 <sup>1</sup> / <sub>2</sub> - 277 <sup>1</sup> / <sub>2</sub> - 278 <sup>1</sup> / <sub>2</sub> - 279 <sup>1</sup> / <sub>2</sub> - 280 <sup>1</sup> / <sub>2</sub> - 281 <sup>1</sup> / <sub>2</sub> - 282 <sup>1</sup> / <sub>2</sub> - 283 <sup>1</sup> / <sub>2</sub> - 284 <sup>1</sup> / <sub>2</sub> - 285 <sup>1</sup> / <sub>2</sub> - 286 <sup>1</sup> / <sub>2</sub> - 287 <sup>1</sup> / <sub>2</sub> - 288 <sup>1</sup> / <sub>2</sub> - 289 <sup>1</sup> / <sub>2</sub> - 290 <sup>1</sup> / <sub>2</sub> - 291 <sup>1</sup> / <sub>2</sub> - 292 <sup>1</sup> / <sub>2</sub> - 293 <sup>1</sup> / <sub>2</sub> - 294 <sup>1</sup> / <sub>2</sub> - 295 <sup>1</sup> / <sub>2</sub> - 296 <sup>1</sup> / <sub>2</sub> - 297 <sup>1</sup> / <sub>2</sub> - 298 <sup>1</sup> / <sub>2</sub> - 299 <sup>1</sup> / <sub>2</sub> - 300 <sup>1</sup> / <sub>2</sub> - 301 <sup>1</sup> / <sub>2</sub> - 302 <sup>1</sup> / <sub>2</sub> - 303 <sup>1</sup> / <sub>2</sub> - 304 <sup>1</sup> / <sub>2</sub> - 305 <sup>1</sup> / <sub>2</sub> - 306 <sup>1</sup> / <sub>2</sub> - 307 <sup>1</sup> / <sub>2</sub> - 308 <sup>1</sup> / <sub>2</sub> - 309 <sup>1</sup> / <sub>2</sub> - 310 <sup>1</sup> / <sub>2</sub> - 311 <sup>1</sup> / <sub>2</sub> - 312 <sup>1</sup> / <sub>2</sub> - 313 <sup>1</sup> / <sub>2</sub> - 314 <sup>1</sup> / <sub>2</sub> - 315 <sup>1</sup> / <sub>2</sub> - 316 <sup>1</sup> / <sub>2</sub> - 317 <sup>1</sup> / <sub>2</sub> - 318 <sup>1</sup> / <sub>2</sub> - 319 <sup>1</sup> / <sub>2</sub> - 320 <sup>1</sup> / <sub>2</sub> - 321 <sup>1</sup> / <sub>2</sub> - 322 <sup>1</sup> / <sub>2</sub> - 323 <sup>1</sup> / <sub>2</sub> - 324 <sup>1</sup> / <sub>2</sub> - 325 <sup>1</sup> / <sub>2</sub> - 326 <sup>1</sup> / <sub>2</sub> - 327 <sup>1</sup> / <sub>2</sub> - 328 <sup>1</sup> / <sub>2</sub> - 329 <sup>1</sup> / <sub>2</sub> - 330 <sup>1</sup> / <sub>2</sub> - 331 <sup>1</sup> / <sub>2</sub> - 332 <sup>1</sup> / <sub>2</sub> - 333 <sup>1</sup> / <sub>2</sub> - 334 <sup>1</sup> / <sub>2</sub> - 335 <sup>1</sup> / <sub>2</sub> - 336 <sup>1</sup> / <sub>2</sub> - 337 <sup>1</sup> / <sub>2</sub> - 338 <sup>1</sup> / <sub>2</sub> - 339 <sup>1</sup> / <sub>2</sub> - 340 <sup>1</sup> / <sub>2</sub> - 341 <sup>1</sup> / <sub>2</sub> - 342 <sup>1</sup> / <sub>2</sub> - 343 <sup>1</sup> / <sub>2</sub> - 344 <sup>1</sup> / <sub>2</sub> - 345 <sup>1</sup> / <sub>2</sub> - 346 <sup>1</sup> / <sub>2</sub> - 347 <sup>1</sup> / <sub>2</sub> - 348 <sup>1</sup> / <sub>2</sub> - 349 <sup>1</sup> / <sub>2</sub> - 350 <sup>1</sup> / <sub>2</sub> - 351 <sup>1</sup> / <sub>2</sub> - 352 <sup>1</sup> / <sub>2</sub> - 353 <sup>1</sup> / <sub>2</sub> - 354 <sup>1</sup> / <sub>2</sub> - 355 <sup>1</sup> / <sub>2</sub> - 356 <sup>1</sup> / <sub>2</sub> - 357 <sup>1</sup> / <sub>2</sub> - 358 <sup>1</sup> / <sub>2</sub> - 359 <sup>1</sup> / <sub>2</sub> - 360 <sup>1</sup> / <sub>2</sub> - 361 <sup>1</sup> / <sub>2</sub> - 362 <sup>1</sup> / <sub>2</sub> - 363 <sup>1</sup> / <sub>2</sub> - 364 <sup>1</sup> / <sub>2</sub> - 365 <sup>1</sup> / <sub>2</sub> - 366 <sup>1</sup> / <sub>2</sub> - 367 <sup>1</sup> / <sub>2</sub> - 368 <sup>1</sup> / <sub>2</sub> - 369 <sup>1</sup> / <sub>2</sub> - 370 <sup>1</sup> / <sub>2</sub> - 371 <sup>1</sup> / <sub>2</sub> - 372 <sup>1</sup> / <sub>2</sub> - 373 <sup>1</sup> / <sub>2</sub> - 374 <sup>1</sup> / <sub>2</sub> - 375 <sup>1</sup> / <sub>2</sub> - 376 <sup>1</sup> / <sub>2</sub> - 377 <sup>1</sup> / <sub>2</sub> - 378 <sup>1</sup> / <sub>2</sub> - 379 <sup>1</sup> / <sub>2</sub> - 380 <sup>1</sup> / <sub>2</sub> - 381 <sup>1</sup> / <sub>2</sub> - 382 <sup>1</sup> / <sub>2</sub> - 383 <sup>1</sup> / <sub>2</sub> - 384 <sup>1</sup> / <sub>2</sub> - 385 <sup>1</sup> / <sub>2</sub> - 386 <sup>1</sup> / <sub>2</sub> - 387 <sup>1</sup> / <sub>2</sub> - 388 <sup>1</sup> / <sub>2</sub> - 389 <sup>1</sup> / <sub>2</sub> - 390 <sup>1</sup> / <sub>2</sub> - 391 <sup>1</sup> / <sub>2</sub> - 392 <sup>1</sup> / <sub>2</sub> - 393 <sup>1</sup> / <sub>2</sub> - 394 <sup>1</sup> / <sub>2</sub> - 395 <sup>1</sup> / <sub>2</sub> - 396 <sup>1</sup> / <sub>2</sub> - 397 <sup>1</sup> / <sub>2</sub> - 398 <sup>1</sup> / <sub>2</sub> - 399 <sup>1</sup> / <sub>2</sub> - 400 <sup>1</sup> / <sub>2</sub> - 401 <sup>1</sup> / <sub>2</sub> - 402 <sup>1</sup> / <sub>2</sub> - 403 <sup>1</sup> / <sub>2</sub> - 404 <sup>1</sup> / <sub>2</sub> - 405 <sup>1</sup> / <sub>2</sub> - 406 <sup>1</sup> / <sub>2</sub> - 407 <sup>1</sup> / <sub>2</sub> - 408 <sup>1</sup> / <sub>2</sub> - 409 <sup>1</sup> / <sub>2</sub> - 410 <sup>1</sup> / <sub>2</sub> - 411 <sup>1</sup> / <sub>2</sub> - 412 <sup>1</sup> / <sub>2</sub> - 413 <sup>1</sup> / <sub>2</sub> - 414 <sup>1</sup> / <sub>2</sub> - 415 <sup>1</sup> / <sub>2</sub> - 416 <sup>1</sup> / <sub>2</sub> - 417 <sup>1</sup> / <sub>2</sub> - 418 <sup>1</sup> / <sub>2</sub> - 419 <sup>1</sup> / <sub>2</sub> - 420 <sup>1</sup> / <sub>2</sub> - 421 <sup>1</sup> / <sub>2</sub> - 422 <sup>1</sup> / <sub>2</sub> - 423 <sup>1</sup> / <sub>2</sub> - 424 <sup>1</sup> / <sub>2</sub> - 425 <sup>1</sup> / <sub>2</sub> - 426 <sup>1</sup> / <sub>2</sub> - 427 <sup>1</sup> / <sub>2</sub> - 428 <sup>1</sup> / <sub>2</sub> - 429 <sup>1</sup> / <sub>2</sub> - 430 <sup>1</sup> / <sub>2</sub> - 431 <sup>1</sup> / <sub>2</sub> - 432 <sup>1</sup> / <sub>2</sub> - 433 <sup>1</sup> / <sub>2</sub> - 434 <sup>1</sup> / <sub>2</sub> - 435 <sup>1</sup> / <sub>2</sub> - 436 <sup>1</sup> / <sub>2</sub> - 437 <sup>1</sup> / <sub>2</sub> - 438 <sup>1</sup> / <sub>2</sub> - 439 <sup>1</sup> / <sub>2</sub> - 440 <sup>1</sup> / <sub>2</sub> - 441 <sup>1</sup> / <sub>2</sub> - 442 <sup>1</sup> / <sub>2</sub> - 443 <sup>1</sup> / <sub>2</sub> - 444 <sup>1</sup> / <sub>2</sub> - 445 <sup>1</sup> / <sub>2</sub> - 446 <sup>1</sup> / <sub>2</sub> - 447 <sup>1</sup> / <sub>2</sub> - 448 <sup>1</sup> / <sub>2</sub> - 449 <sup>1</sup> / <sub>2</sub> - 450 <sup>1</sup> / <sub>2</sub> - 451 <sup>1</sup> / <sub>2</sub> - 452 <sup>1</sup> / <sub>2</sub> - 453 <sup>1</sup> / <sub>2</sub> - 454 <sup>1</sup> / <sub>2</sub> - 455 <sup>1</sup> / <sub>2</sub> - 456 <sup>1</sup> / <sub>2</sub> - 457 <sup>1</sup> / <sub>2</sub> - 458 <sup>1</sup> / <sub>2</sub> - 459 <sup>1</sup> / <sub>2</sub> - 460 <sup>1</sup> / <sub>2</sub> - 461 <sup>1</sup> / <sub>2</sub> - 462 <sup>1</sup> / <sub>2</sub> - 463 <sup>1</sup> / <sub>2</sub> - 464 <sup>1</sup> / <sub>2</sub> - 465 <sup>1</sup> / <sub>2</sub> - 466 <sup>1</sup> / <sub>2</sub> - 467 <sup>1</sup> / <sub>2</sub> - 468 <sup>1</sup> / <sub>2</sub> - 469 <sup>1</sup> / <sub>2</sub> - 470 <sup>1</sup> / <sub>2</sub> - 471 <sup>1</sup> / <sub>2</sub> - 472 <sup>1</sup> / <sub>2</sub> - 473 <sup>1</sup> / <sub>2</sub> - 474 <sup>1</sup> / <sub>2</sub> - 475 <sup>1</sup> / <sub>2</sub> - 476 <sup>1</sup> / <sub>2</sub> - 477 <sup>1</sup> / <sub>2</sub> - 478 <sup>1</sup> / <sub>2</sub> - 479 <sup>1</sup> / <sub>2</sub> - 480 <sup>1</sup> / <sub>2</sub> - 481 <sup>1</sup> / <sub>2</sub> - 482 <sup>1</sup> / <sub>2</sub> - 483 <sup>1</sup> / <sub>2</sub> - 484 <sup>1</sup> / <sub>2</sub> - 485 <sup>1</sup> / <sub>2</sub> - 486 <sup>1</sup> / <sub>2</sub> - 487 <sup>1</sup> / <sub>2</sub> - 488 <sup>1</sup> / <sub>2</sub> - 489 <sup>1</sup> / <sub>2</sub> - 490 <sup>1</sup> / <sub>2</sub> - 491 <sup>1</sup> / <sub>2</sub> - 492 <sup>1</sup> / <sub>2</sub> - 493 <sup>1</sup> / <sub>2</sub> - 494 <sup>1</sup> / <sub>2</sub> - 495 <sup>1</sup> / <sub>2</sub> - 496 <sup>1</sup> / <sub>2</sub> - 497 <sup>1</sup> / <sub>2</sub> - 498 <sup>1</sup> / <sub>2</sub> - 499 <sup>1</sup> / <sub>2</sub> - 500 <sup>1</sup> / <sub>2</sub> - 501 <sup>1</sup> / <sub>2</sub> - 502 <sup>1</sup> / <sub>2</sub> - 503 <sup>1</sup> / <sub>2</sub> - 504 <sup>1</sup> / <sub>2</sub> - 505 <sup>1</sup> / <sub>2</sub> - 506 <sup>1</sup> / <sub>2</sub> - 507 <sup>1</sup> / <sub>2</sub> - 508 <sup>1</sup> / <sub>2</sub> - 509 <sup>1</sup> / <sub>2</sub> - 510 <sup>1</sup> / <sub>2</sub> - 511 <sup>1</sup> / <sub>2</sub> - 512 <sup>1</sup> / <sub>2</sub> - 513 <sup>1</sup> / <sub>2</sub> - 514 <sup>1</sup> / <sub>2</sub> - 515 <sup>1</sup> / <sub>2</sub> - 516 <sup>1</sup> / <sub>2</sub> - 517 <sup>1</sup> / <sub>2</sub> - 518 <sup>1</sup> / <sub>2</sub> - 519 <sup>1</sup> / <sub>2</sub> - 520 <sup>1</sup> / <sub>2</sub> - 521 <sup>1</sup> / <sub>2</sub> - 522 <sup>1</sup> / <sub>2</sub> - 523 <sup>1</sup> / <sub>2</sub> - 524 <sup>1</sup> / <sub>2</sub> - 525 <sup>1</sup> / <sub>2</sub> - 526 <sup>1</sup> / <sub>2</sub> - 527 <sup>1</sup> / <sub>2</sub> - 528 <sup>1</sup> / <sub>2</sub> - 529 <sup>1</sup> / <sub>2</sub> - 530 <sup>1</sup> / <sub>2</sub> - 531 <sup>1</sup> / <sub>2</sub> - 532 <sup>1</sup> / <sub>2</sub> - 533 <sup>1</sup> / <sub>2</sub> - 534 <sup>1</sup> / <sub>2</sub> - 535 <sup>1</sup> / <sub>2</sub> - 536 <sup>1</sup> / <sub>2</sub> - 537 <sup>1</sup> / <sub>2</sub> - 538 <sup>1</sup> / <sub>2</sub> - 539 <sup>1</sup> / <sub>2</sub> - 540 <sup>1</sup> / <sub>2</sub> - 541 <sup>1</sup> / <sub>2</sub> - 542 <sup>1</sup> / <sub>2</sub> - 543 <sup>1</sup> / <sub>2</sub> - 544 <sup>1</sup> / <sub>2</sub> - 545 <sup>1</sup> / <sub>2</sub> - 546 <sup>1</sup> / <sub>2</sub> - 547 <sup>1</sup> / <sub>2</sub> - 548 <sup>1</sup> / <sub>2</sub> - 549 <sup>1</sup> / <sub>2</sub> - 550 <sup>1</sup> / <sub>2</sub> - 551 <sup>1</sup> / <sub>2</sub> - 552 <sup>1</sup> / <sub>2</sub> - 553 <sup>1</sup> / <sub>2</sub> - 554 <sup>1</sup> / <sub>2</sub> - 555 <sup>1</sup> / <sub>2</sub> - 556 <sup>1</sup> / <sub>2</sub> - 557 <sup>1</sup> / <sub>2</sub> - 558 <sup>1</sup> / <sub>2</sub> - 559 <sup>1</sup> / <sub>2</sub> - 560 <sup>1</sup> / <sub>2</sub> - 561 <sup>1</sup> / <sub>2</sub> - 562 <sup>1</sup> / <sub>2</sub> - 563 <sup>1</sup> / <sub>2</sub> - 564 <sup>1</sup> / <sub>2</sub> - 565 <sup>1</sup> / <sub>2</sub> - 566 <sup>1</sup> / <sub>2</sub> - 567 <sup>1</sup> / <sub>2</sub> - 568 <sup>1</sup> / <sub>2</sub> - 569 <sup>1</sup> / <sub>2</sub> - 570 <sup>1</sup> / <sub>2</sub> - 571 <sup>1</sup> / <sub>2</sub> - 572 <sup>1</sup> / <sub>2</sub> - 573 <sup>1</sup> / <sub>2</sub> - 574 <sup>1</sup> / <sub>2</sub> - 575 <sup>1</sup> / <sub>2</sub> - 576 <sup>1</sup> / <sub>2</sub> - 577 <sup>1</sup> / <sub>2</sub> - 578 <sup>1</sup> / <sub>2</sub> - 579 <sup>1</sup> / <sub>2</sub> - 580 <sup>1</sup> / <sub>2</sub> - 581 <sup>1</sup> / <sub>2</sub> - 582 <sup>1</sup> / <sub>2</sub> - 583 <sup>1</sup> / <sub>2</sub> - 584 <sup>1</sup> / <sub>2</sub> - 585 <sup>1</sup> / <sub>2</sub> - 586 <sup>1</sup> / <sub>2</sub> - 587 <sup>1</sup> / <sub>2</sub> - 588 <sup>1</sup> / <sub>2</sub> - 589 <sup>1</sup> / <sub>2</sub> - 590 <sup>1</sup> / <sub>2</sub> - 591 <sup>1</sup> / <sub>2</sub> - 592 <sup>1</sup> / <sub>2</sub> - 593 <sup>1</sup> / <sub>2</sub> - 594 <sup>1</sup> / <sub>2</sub> - 595 <sup>1</sup> / <sub>2</sub> - 596 <sup>1</sup> / <sub>2</sub> - 597 <sup>1</sup> / <sub>2</sub> - 598 <sup>1</sup> / <sub>2</sub> - 599 <sup>1</sup> / <sub>2</sub> - 600 <sup>1</sup> / <sub>2</sub> - 601 <sup>1</sup> / <sub>2</sub> - 602 <sup>1</sup> / <sub>2</sub> - 603 <sup>1</sup> / <sub>2</sub> - 604 <sup>1</sup> / <sub>2</sub> - 605 <sup>1</sup> / <sub>2</sub> - 606 <sup>1</sup> / <sub>2</sub> - 607 <sup>1</sup> / <sub>2</sub> - 608 <sup>1</sup> / <sub>2</sub> - 609 <sup>1</sup> / <sub>2</sub> - 610 <sup>1</sup> / <sub>2</sub> - 611 <sup>1</sup> / <sub>2</sub> - 612 <sup>1</sup> / <sub>2</sub> - 613 <sup>1</sup> / <sub>2</sub> - 614 <sup>1</sup> / <sub>2</sub> - 615 <sup>1</sup> / <sub>2</sub> - 616 <sup>1</sup> / <sub>2</sub> - 617 <sup>1</sup> / <sub>2</sub> - 618 <sup>1</sup> / <sub>2</sub> - 619 <sup>1</sup> / <sub>2</sub> - 620 <sup>1</sup> / <sub>2</sub> - 621 <sup>1</sup> / <sub>2</sub> - 622 <sup>1</sup> / <sub>2</sub> - 623 <sup>1</sup> / <sub>2</sub> - 624 <sup>1</sup> / <sub>2</sub> - 625 <sup>1</sup> / <sub>2</sub> - 626 <sup>1</sup> / <sub>2</sub> - 627 <sup>1</sup> / <sub>2</sub> - 628 <sup>1</sup> / <sub>2</sub> - 629 <sup>1</sup> / <sub>2</sub> - 630 <sup>1</sup> / <sub>2</sub> - 631 <sup>1</sup> / <sub>2</sub> - 632 <sup>1</sup> / <sub>2</sub> - 633 <sup>1</sup> / <sub>2</sub> - 634 <sup>1</sup> / <sub>2</sub> - 635 <sup>1</sup> / <sub>2</sub> - 636 <sup>1</sup> / <sub>2</sub> - 637 <sup>1</sup> / <sub>2</sub> - 638 <sup>1</sup> / <sub>2</sub> - 639 <sup>1</sup> / <sub>2</sub> - 640 <sup>1</sup> / <sub>2</sub> - 641 <sup>1</sup> / <sub>2</sub> - 642 <sup>1</sup> / <sub>2</sub> - 643 <sup>1</sup> / <sub>2</sub> - 644 <sup>1</sup> / <sub>2</sub> - 645 <sup>1</sup> /<



• • •

• • • • •

• • •

• • •

• • • • •

• • •

• • •

• • • • •

• • • • •

• • • • •

• • •

• • • • •

• • •

• • •

• • • • •

• • • • •

• • •

• • •

• • •

• • • • •

• • •

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 11711

BIRTH NO.

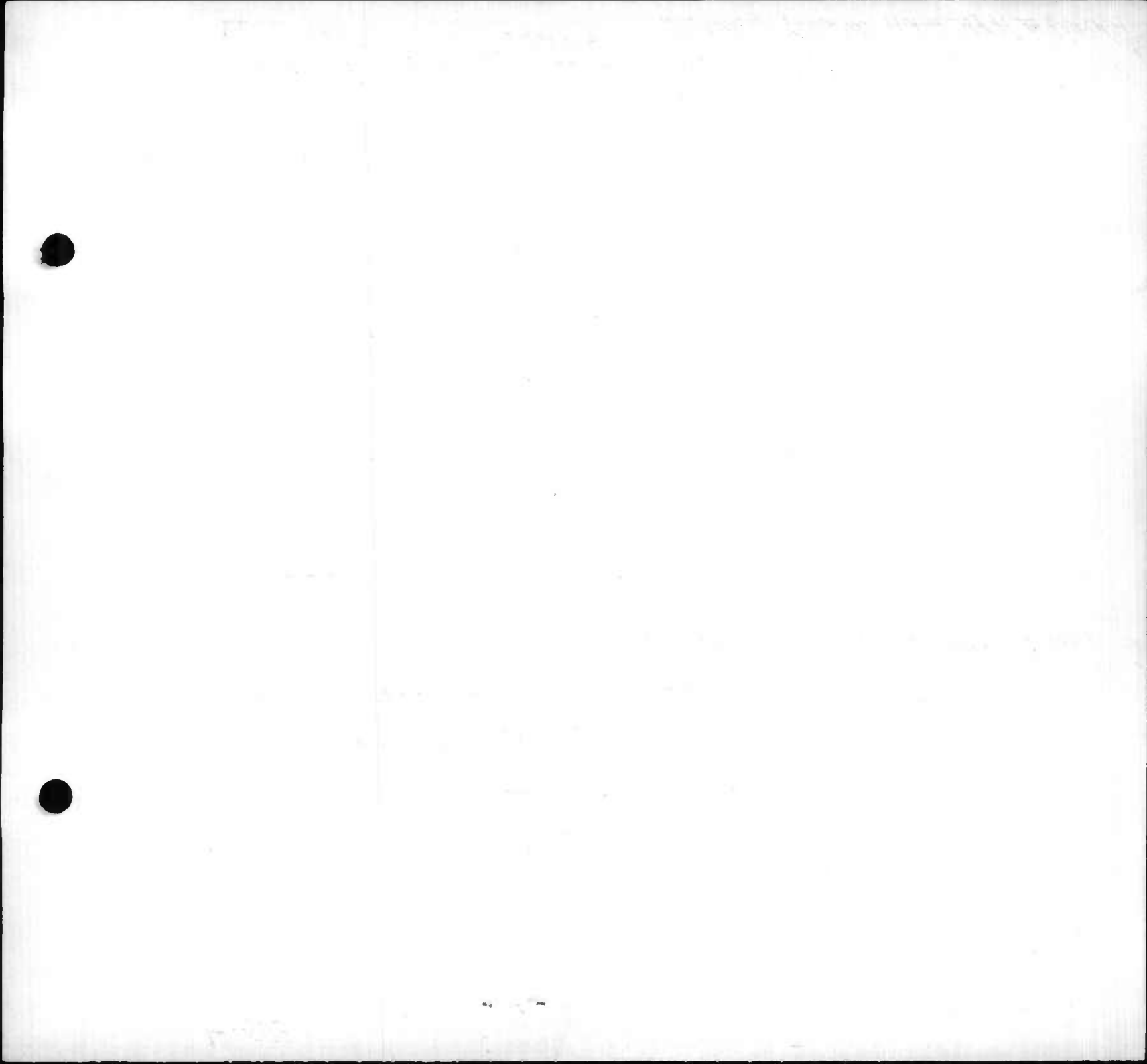
1. NAME OF DECEASED (Type or Print) Etta Knight		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 12 Day 7 Year 72 Hour 10:50A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2303 Frederick Avenue		3. DATE PRONOUNCED DEAD Month 12 Day 7 Year 72 Hour 10:50A. M.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2005	
9. DATE OF BIRTH 8/12/16		10. AGE (In years last birthday) 56	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lewis S. Moore		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
15. MOTHER'S MAIDEN NAME Ethel J. Bowler		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO	
17. SOCIAL SECURITY NO. 313 20 1185		18. INFORMANT George W. Knight	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Fatty metamorphosis of liver DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <i>W P Mulloy</i> M.D. EXAMINER'S NAME (Type) William P. Mulloy, M.D. DATE SIGNED 12-8-72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/11/72	
24C. NAME of CEMETERY or CREMATORY Cedar Hill		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1972		25B. NAME OF REGISTRAR <i>Sidney Johnston</i>	
25C. FUNERAL DIRECTOR Herbert E. Nutter		ADDRESS 3035 W. North Ave	

WAT 1113-7

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

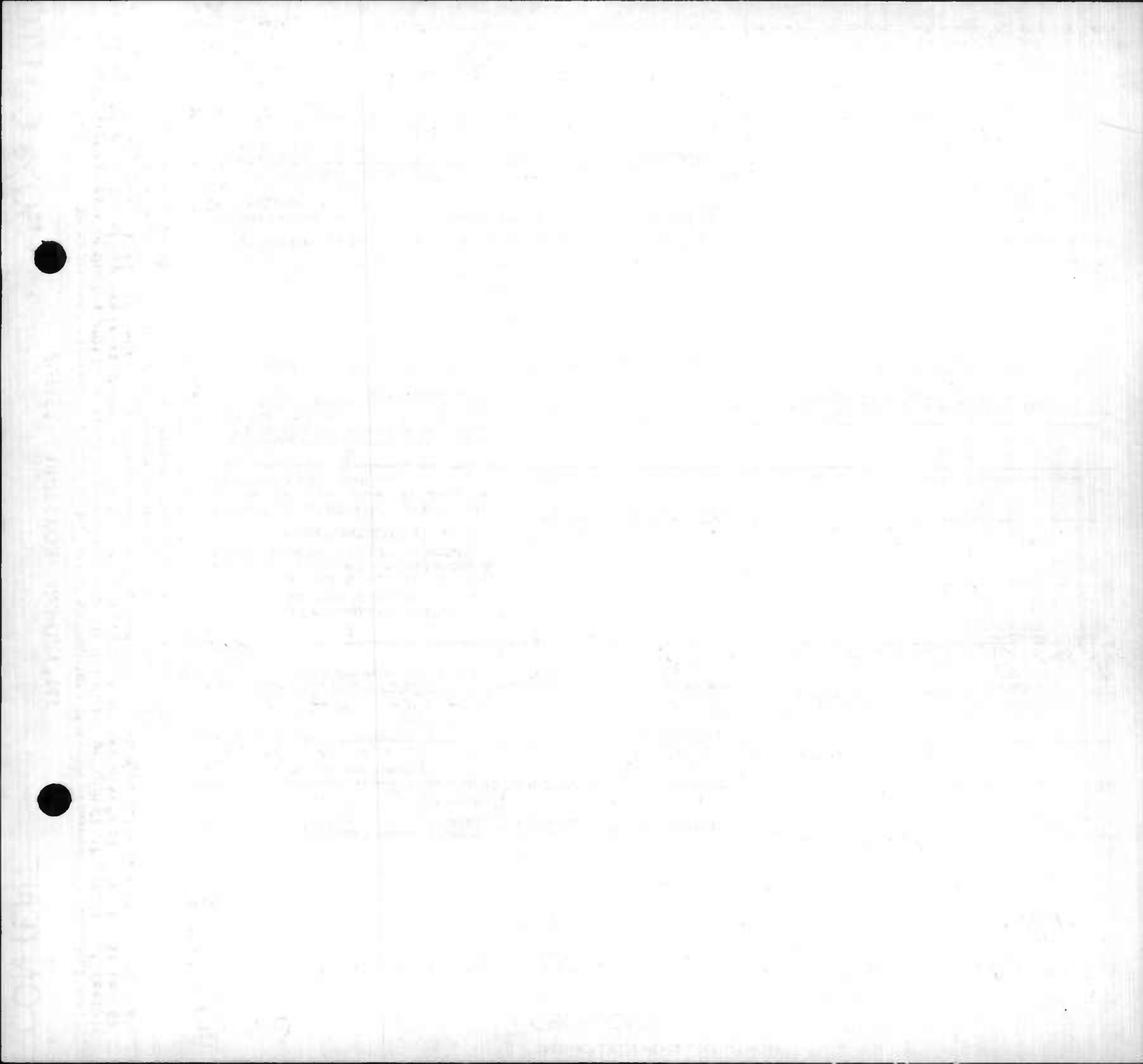
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 11712	
72 11712				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) PAUL P. HAMMOND		2. DATE AND HOUR OF DEATH 12/8/72 11:35 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD. B. COUNTY 1605		5. CITY OR TOWN BAITIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		6. STREET AND NUMBER		7. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
LUTHERAN HOSPITAL		2426 HARIEM AVE.			
8. SEX M		9. RACE B.		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
11. DATE OF BIRTH 2-28-02		12. AGE (In years last birthday) 70		13. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postal Worker		15. KIND OF BUSINESS OR INDUSTRY retired		16. BIRTHPLACE (State or foreign country) MD. Balto.	
17. CITIZEN OF WHAT COUNTRY? U.S.A.		18. FATHER'S NAME John W. Hammond		19. MOTHER'S MAIDEN NAME Jennie Talbott	
20. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) [If yes, give war or dates of service] No		21. SOCIAL SECURITY NO. 218-34-0749		22. INFORMANT John W. Hammond Jr. 844 Edmondson Ave.	
23. CAUSE OF DEATH		24. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		25. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH	
492X1		5min.		(A) IMMEDIATE CAUSE Acute Cardiorespiratory Arrest	
DUE TO, OR AS A CONSEQUENCE OF:		(B) Congestive Heart Failure		DUE TO, OR AS A CONSEQUENCE OF:	
(C) Chronic pulmonary Emphysema		DUE TO, OR AS A CONSEQUENCE OF:		(D) Chronic pulmonary Bullous Emphysema	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
26. DATE OF OPERATION		27. CONDITION FOR WHICH OPERATION WAS PERFORMED		28. AUTOPSY? (Yes or No) No	
29. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		30. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		31. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
32. ACCIDENT WAS UNDERLIEING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		33. TIME OF INJURY (Month) (Day) (Year) (Hour)		34. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
35. HOW DID INJURY OCCUR?		36. I certify that (I) (this hospital) attended the deceased from 12/3/72 19 to 12/8/72 19 72		37. that (I) (we) lost saw the deceased alive on 12/8/72 19 72 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
38. SIGNATURE S. S. DONGRE		39. DATE SIGNED 12/8/72		40. PHYSICIAN'S NAME (Type) S.S. DONGRE	
41. ADDRESS 730 Ashburton St. - Balto. Md. 21216		42. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.		43. LOCATION Balto. Md.	
44. DATE REC'D BY HEALTH DEPT. DEC 8 1972		45. NAME OF REGISTRAR		46. FUNERAL DIRECTOR William J. General Home 319 N. Hollister	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	STATE OF MARYLAND - DEATH
7-260		72 11713		72 11713	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Fisher, Walter M.		12/7/72 10:18 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
4 B or Se cours		A. STATE 1089 W. Fayette Street Md.			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER		1802	
		1089 W. Fayette St.			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
male	Negro	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	12-24-10	61	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
truck driver				Baltimore Md.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Walter Fisher		Mary Chase			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		212-01-8988		Vivian Matthews 4202 Rogers Ave	
18. CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
412.41		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		10 h.	
		ACUTE PULMONARY EDEMA			
		(B) DUE TO, OR AS A CONSEQUENCE OF:		years	
		As CVD -> C.H.F.			
		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/7/72 3:30 PM to 12/7 10:18 PM 1972 that (I) (we) last saw the deceased alive on 12/7 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Alf Herrero M.D.		12/7/72			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
ALFREDO HERRERA M.D.		Thon Secours Hospital			
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		12/12/72		Arboretum Memorial Park	
				Arboretum Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
DEC 8 1972		Sidney W. ...		Williams Funeral Home 3198 Schroeder St	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				72 11711	
G-300				72 11711	
P. 72 11711				REG. NO. 72 11711	
BIRTH NO.				STATE OF MARYLAND - DISTRICT	
1. NAME OF DECEASED (Type or Print) <b>LEE GOODE JR</b>			2. DATE AND HOUR OF DEATH <b>92/8/72 9/30 A M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>UNION MEMORIAL HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>722 McCABE AV. BALTIMORE</b>		
5. SEX <b>MALE</b>	6. RACE <b>BLACK</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-21-27</b>	9. AGE (In years last birthday) <b>44</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NOT KNOWN</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>	11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>LEO B. GOODE SR.</b>			14. MOTHER'S MAIDEN NAME <b>EASTON ALLISON</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES UNKNOWN</b>		16. SOCIAL SECURITY NO. <b>225-32-5264</b>	17. INFORMANT ADDRESS <b>Martha L. Goode 722 McCabe Ave.</b>		
18. <b>485X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>Acute respiratory arrest</b> <b>BILATERAL BRONCHOPNEUMONIA 3 WEEKS</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>IMMEDIATE</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>—</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12/8/72</b> to <b>12/8/72</b> , that (I) (we) last saw the deceased alive on <b>12/8/72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Debra H. Jones</b>				23B. DATE SIGNED <b>12/8/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>DR. J. H. HARRIS</b>				23D. ADDRESS <b>—</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-12-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto., MD.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 8 1972</b>			
25B. NAME OF REGISTRAR <b>—</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Wm. G. March 928 E North Ave.</b>			

1914

1915

1916

1917

1918

1919

1920

1921

1922

1923

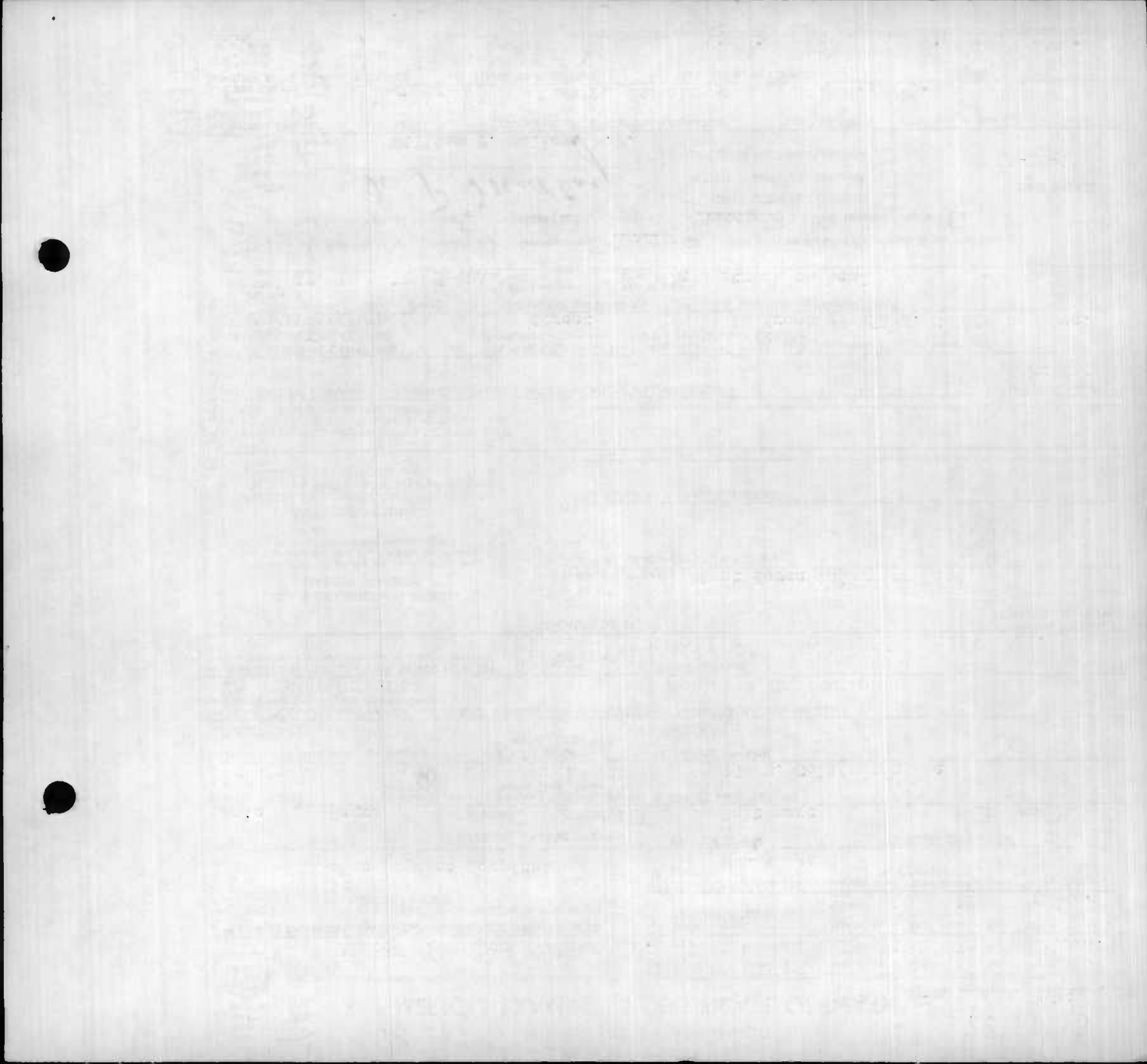
1924

M-450

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH		3. DATE PRONOUNCED DEAD		4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
		Alfred T. (Muller) Mullen Sr.		Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year		12 10 72		Hour	
						Month Day Year		12 10 72		Hour	
										6:05 A. M.	
										6:05 A. M.	
										A. STATE	
										B. COUNTY	
										Maryland	
										703	
6. SEX		7. RACE		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		C. CITY OR TOWN		D. INSIDE CITY LIMITS?			
Male		Negro		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Baltimore		YES <input type="checkbox"/> NO <input type="checkbox"/>			
9. DATE OF BIRTH		10. AGE (in years last birthday)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
12-16-31		40		Maryland				Thomas Mullen		KX Truck Driver	
										15. MOTHER'S MAIDEN NAME	
										Rosebud Patterson	
										16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
										No	
										17. SOCIAL SECURITY NO.	
										215-24-3512	
										18. INFORMANT	
										ADDRESS	
										21. MEDICAL CERTIFICATION	
										22. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
										23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>	
										24. DATE	
										12-14-72	
										25. NAME OF REGISTRAR	
										William P. Mulloy, M.D.	
										26. FUNERAL DIRECTOR	
										Wm. C. March	
										ADDRESS	
										928 E. North Ave.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 11716	
72 11716 CERTIFICATE OF DEATH				STATE OF MARYLAND-DEMD	
BIRTH NO. <u>A-450</u>		1. NAME OF DECEASED (Type or Print) <u>Ruth Allen</u>			
2. DATE AND HOUR OF DEATH <u>12/9/72</u> <u>6<sup>45</sup> A.M.</u>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION <u>48 Md. General Hospital</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
A. STATE <u>Md.</u>		B. COUNTY <u>BALTO</u>		C. CITY OR TOWN <u>Baltimore</u>	
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <u>George Washington Nursing Home, 607 Pennsylvania Ave.</u>			
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/1/1900</u>	9. AGE (In years last birthday) <u>72</u>	10. Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>VA</u>	
12. CITIZEN OF WHAT COUNTRY <u>US</u>		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME <u>CARRIE Pittman</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-10-0346</u>		17. INFORMANT <u>Chart</u>	
18. <u>57191</u> CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <u>hepatic coma</u>		<u>16 days</u>	
DUE TO, OR AS A CONSEQUENCE OF:		(B) <u>Liver cirrhosis</u>		?	
DUE TO, OR AS A CONSEQUENCE OF:		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <u>11/12</u> 19 <u>72</u> to <u>12/5</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>12/5</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>James H. Biddison</u>		23B. DATE SIGNED <u>12/9/72</u>		23C. PHYSICIAN'S NAME (Type) <u>JAMES H. BIDDISON</u>	
23D. ADDRESS <u>Md. General Hospital</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>12-13-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 8 1972</u>		25B. NAME OF REGISTRAR <u>Wm. J. MARCH</u>		25C. FUNERAL DIRECTOR ADDRESS <u>928 E North Ave</u>	

11/15/72-Adm  
403 F Lorraine 21221

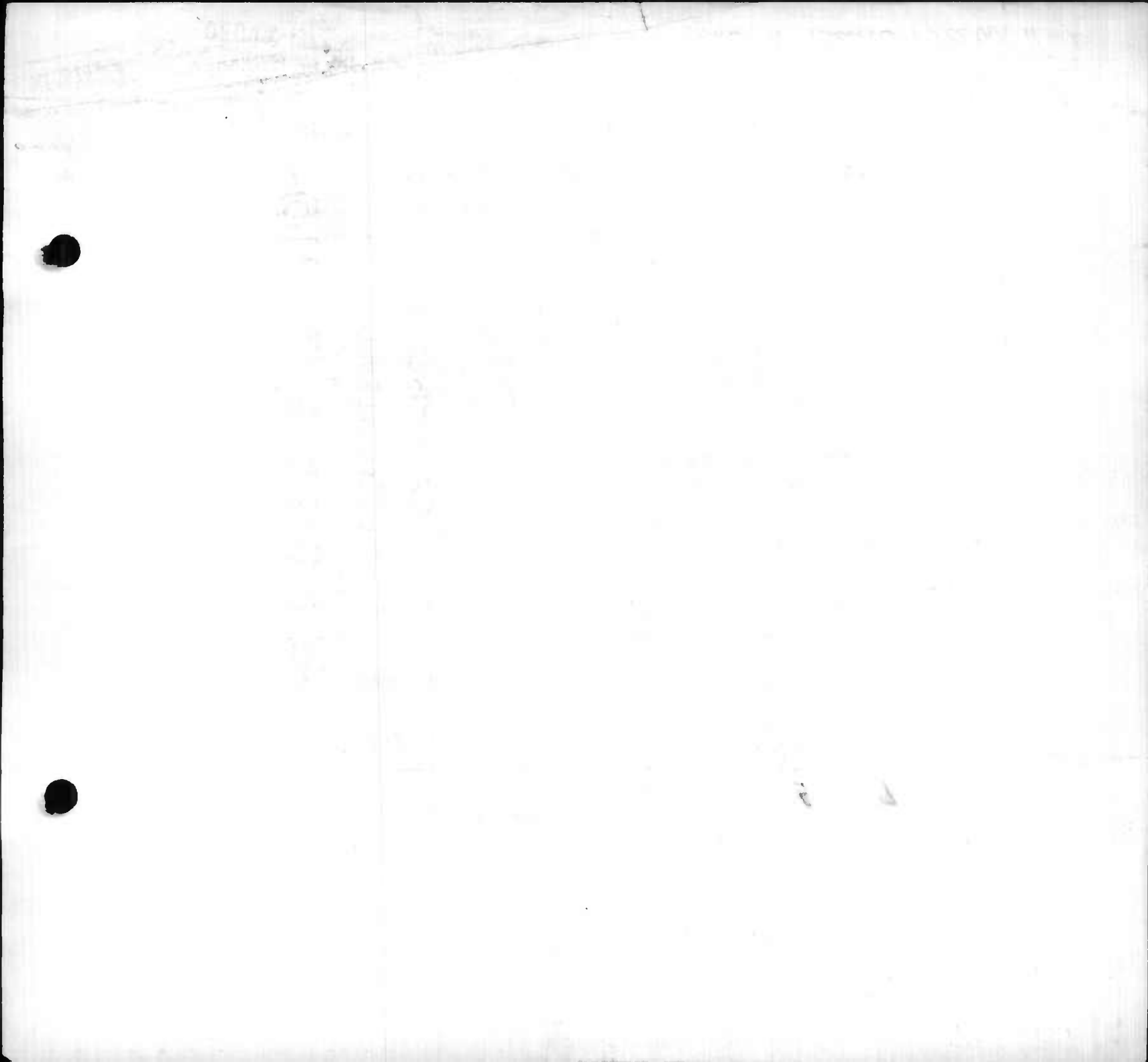


**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 11717		REG. NO. 72 11717	
T-413				72 11717		STATE OF MARYLAND DEPT	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>ELIZABETH TALBOTT</b>				2. DATE AND HOUR OF DEATH <b>DECEMBER 8, 1972 10:47 AM</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>LUTHERAN HOSPITAL OF MARYLAND</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1608</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3620 EDMONSON AVE.</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>BLACK</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 16, 1915</b>		9. AGE (In years last birthday) <b>57</b>	If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>UNEMPLOYED</b>		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME —				14. MOTHER'S MAIDEN NAME <b>ELIZA HOLLINGSWORTH</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNKNOWN</b>				16. SOCIAL SECURITY NO. —		17. INFORMANT <b>FRANKLIN TALBOTT</b> ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH <b>CARDIORESPIRATORY ARREST</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 MINUTES</b>	
				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>HEMORRHAGE, PROBABLY</b>		<b>20 MINUTES</b>	
				(B) <b>COLONIC</b> DUE TO, OR AS A CONSEQUENCE OF: <b>TERMINAL CARCINOMA OF THE COLON</b>		<b>10 DAYS</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <b>11-30-72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CARCINOMA COLON</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>NOV. 28</b> 19 <b>72</b> to <b>DEC 8</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>DEC-8</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>A. Gatzdula M.D.</b>				23B. DATE SIGNED <b>12-8-72</b>			
23C. PHYSICIAN'S NAME (Type) <b>ANTONIO GATDULA, M.D.</b>				23D. ADDRESS <b>LUTHERAN HOSP. OF MD.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/12/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>St. James Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Carroll, County Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 12 1972</b>		25B. NAME OF REGISTRAR <b>Franklin Talbott</b>		25C. FUNERAL DIRECTOR <b>Franklin Talbott</b> ADDRESS <b>1712 W. North</b>			





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 11718

BIRTH NO.

## 1. NAME OF DECEASED

(Type or Print)

Blanche Taylor

2. DATE  
OF  
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

12

7

72

2:55 P. M.

## 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

39 Provident Hospital

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

12

7

72

2:55 P. M.

## 5. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission)

A. STATE

B. COUNTY

Maryland

1504

## 6. SEX

Female

## 7. RACE

Negro

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

## C. CITY OR TOWN

Baltimore

## D. INSIDE CITY LIMITS?

YES ☒NO ☐

## 9. DATE OF BIRTH

3/25/20

10. AGE (in years  
lost birthday)

52

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

## E. STREET AND NUMBER

2135 N. Fulton Avenue

## 11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME

William Shared

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Nurse Assistant

## 14B. KIND OF BUSINESS OR INDUSTRY

## 15. MOTHER'S MAIDEN NAME

Emma Jones

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW II

17. SOCIAL  
SECURITY NO.

## 18. INFORMANT

## ADDRESS

Mrs. Rosetta D. Carter 5 Sugarloaf Court

## 19.

## CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) IMMEDIATE CAUSE Carbon monoxide poisoning  
DUE TO, OR AS A CONSEQUENCE OF:

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF:

(C) \_\_\_\_\_

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

## 20A. DATE OF OPERATION

## 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

## 21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)

house

22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

2135 N. Fulton Avenue

22D. TIME  
OF INJURY  
(APPROX.)

12 6 72 2:15 P.M.

## 22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

## 22F. HOW DID INJURY OCCUR?

house fire

## 23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

William P. Mulloy, M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-8-72

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

## 24B. DATE

12/11/72

## 24C. NAME of CEMETERY or CREMATORY

Maryland Nat'l Mem Park

## 24D. LOCATION (City, town, or county)

Laurel, Maryland

(State)

## 25A. DATE REC'D BY HEALTH DEPT

DEC 12 1972

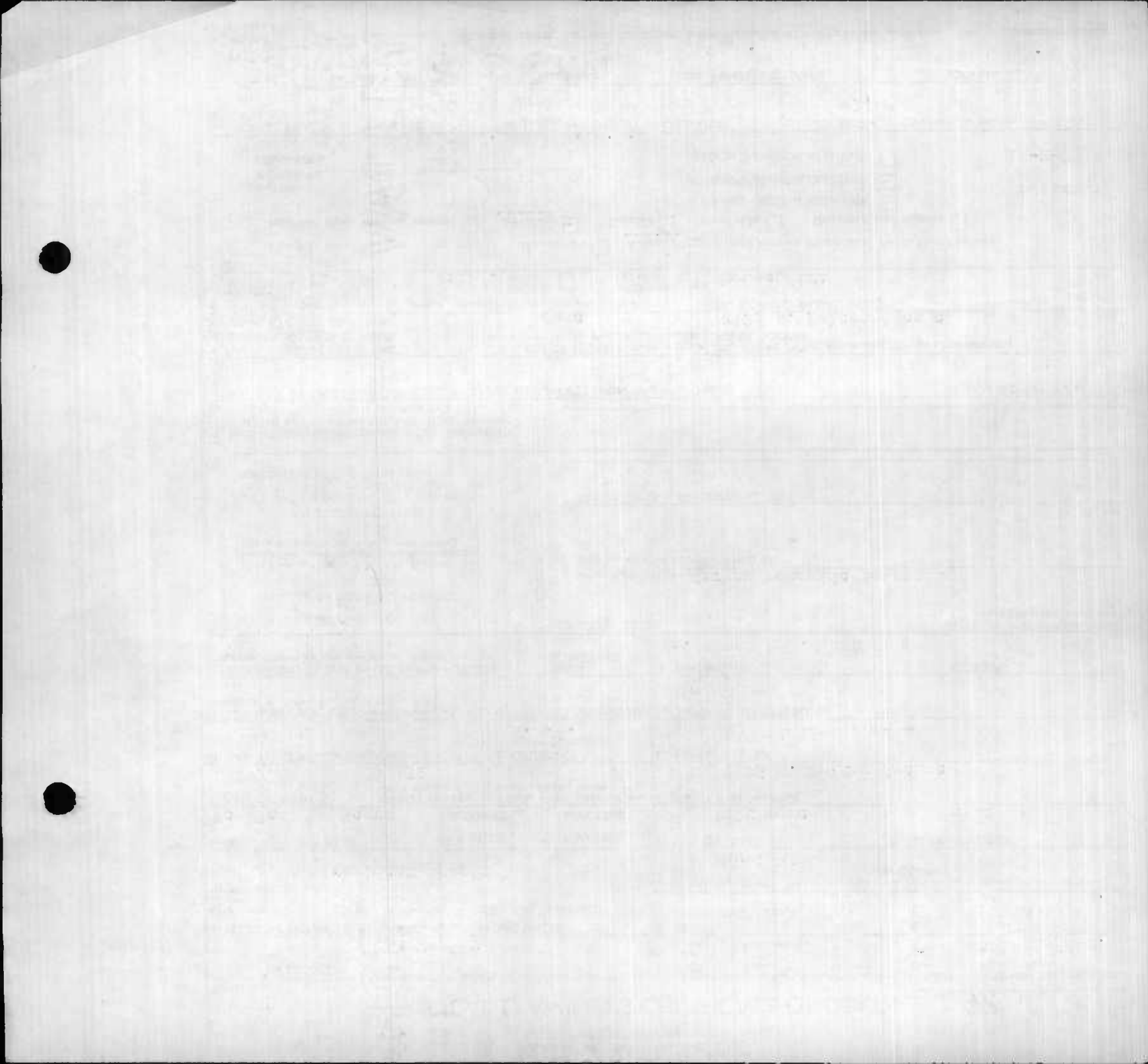
## 25B. NAME OF REGISTRAR

## 25C. FUNERAL DIRECTOR

Mary E. Law

## ADDRESS

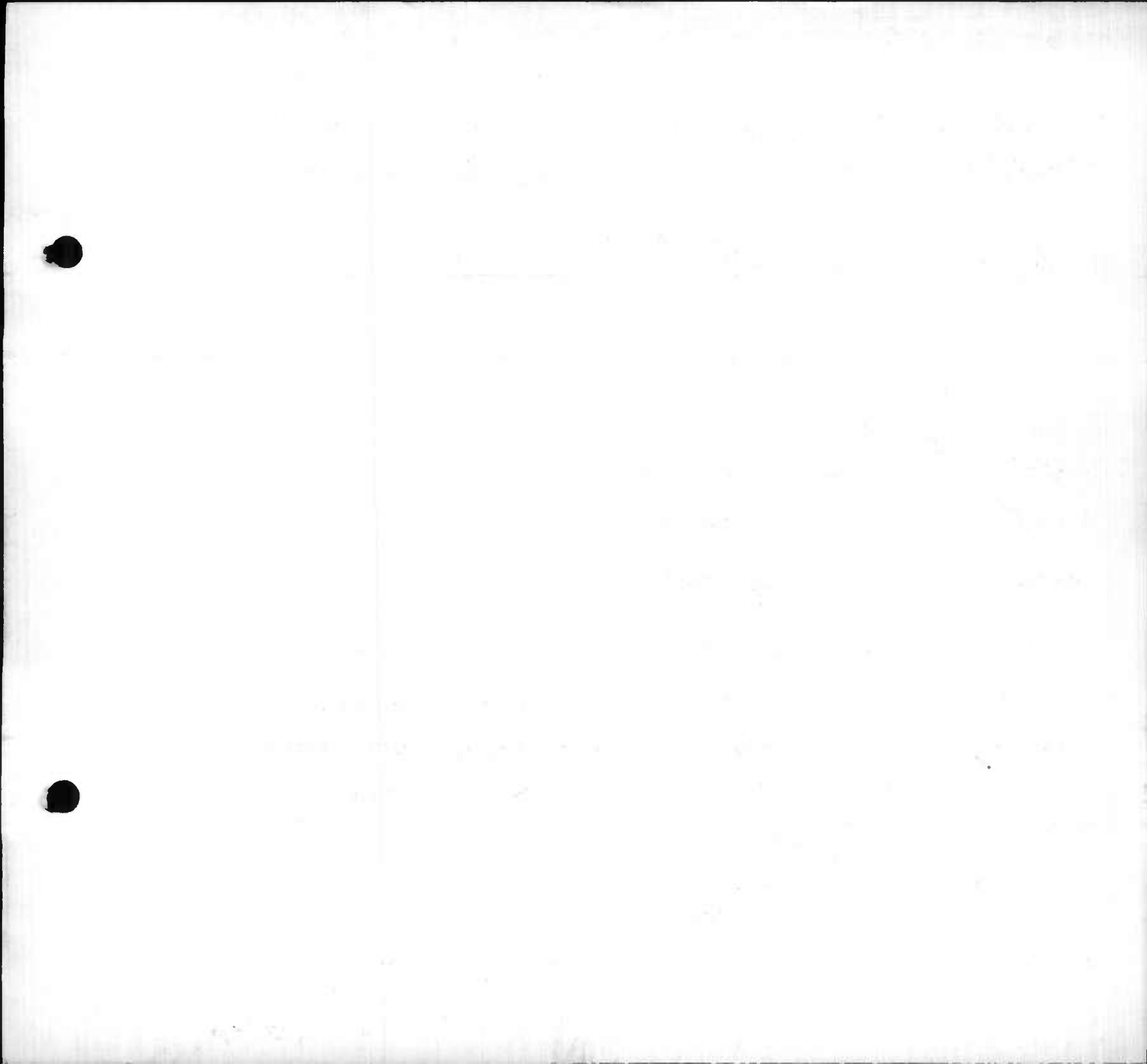
802 Madison Ave.



# FUNERAL DIRECTOR: IMPORTANT

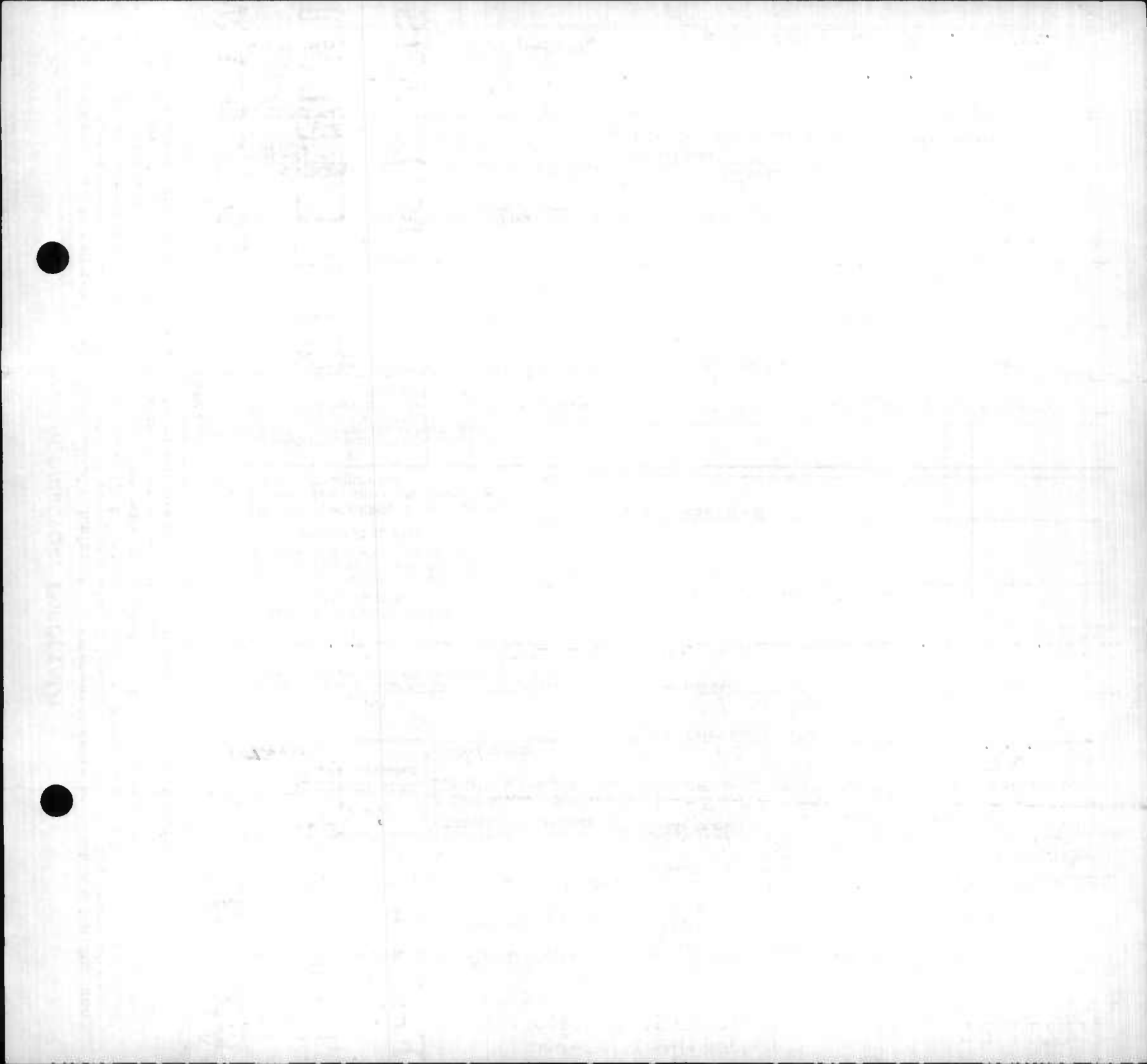
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-620		72 11719		BALTIMORE CITY HEALTH DEPARTMENT		72 11719	
BIRTH NO.		72 11719		CERTIFICATE OF DEATH		REG. NO. 72 11719	
1. NAME OF DECEASED (Type or Print) <u>Amalia Price</u>				2. DATE AND HOUR OF DEATH <u>12-8-72</u> <u>2:15 P.</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>HARBOR VIEW NURSING HOME</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>902</u>			
5. SEX <u>Female</u>		6. RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/29/89</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK - RET.</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>BAKER SUPPLY</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN A. STAMP</u>				14. MOTHER'S MAIDEN NAME <u>LOUISE WERNER</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>217-22-8349</u>		17. INFORMANT <u>John W. Price - 404 Montrose Ave</u>			
18. <u>2309 I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Hypertension Cr disease</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
				(B) <u>Diabetes mellitus</u>		<u>years</u>	
				(C) <u>Chronic renal failure</u>		<u>years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Paroxysmal Atrial Fibrillation</u>						<u>years</u>	
19A. DATE OF OPERATION <u>12/8/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY? (Yes or No) <u>—</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>—</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>—</u>		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>			
22. I certify that (I) (this hospital) attended the deceased from <u>11/17</u> 19 <u>72</u> to <u>12/8</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>12/8</u> 19 <u>72</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>[Signature]</u>				23B. DATE SIGNED <u>12/8/72</u>		23C. PHYSICIAN'S NAME (Type) <u>Dr. [Signature]</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-11-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Woodlawn Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 12 1972</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>[Signature]</u>		25D. ADDRESS <u>[Address]</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 11720</u>
72 11720				STATE OF MARYLAND - BALTIMORE
1. NAME OF DECEASED (Type or Print) <u>SHELDON JOSEPH</u>		2. DATE AND HOUR OF DEATH <u>12/11/72</u> <u>4-30</u> <u>A</u> <u>M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>2402</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>SOUTH BALTIMORE GENERAL HOSPITAL</u> <u>43</u>		C. CITY OR TOWN <u>Balto.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		E. STREET AND NUMBER <u>307 E. Hamburg St.</u>		
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-8-21</u>	9. AGE (In years last birthday) <u>51</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fireman</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Shipyard</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>William</u>		14. MOTHER'S MAIDEN NAME <u>CLUNEY</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>W.W.2</u>		16. SOCIAL SECURITY NO. <u>218-18-3967</u>		17. INFORMANT <u>Mrs. Helen Sheldon</u> ADDRESS <u>307 E. Hamburg St. 21230</u>
18. <u>162.1</u> I		CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <u>CARCINOMA LUNGA</u> DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		
(C)				
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>12-2-</u> <u>1972</u> to <u>12-11-1972</u> that (I) (we) last saw the deceased alive on <u>12-11-</u> <u>1972</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Seeni</u> <u>MD</u> DEGREE		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED
23C. PHYSICIAN'S NAME (Type) <u>SEENI</u>		23D. ADDRESS <u>MD South Baltimore general hospital</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-14-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem. Park</u>
24D. LOCATION (City, town, or county) <u>Balto. Md.</u>		24E. STATE <u>MD</u>		
25A. DATE RECEIVED BY HEALTH DEPT. <u>DEC 12 1972</u>		25B. NAME OF REGISTRAR <u>Sidney Johnston</u>		25C. FUNERAL DIRECTOR <u>McCully Funeral Home</u> ADDRESS <u>130 E. Fort Ave. 21230</u>





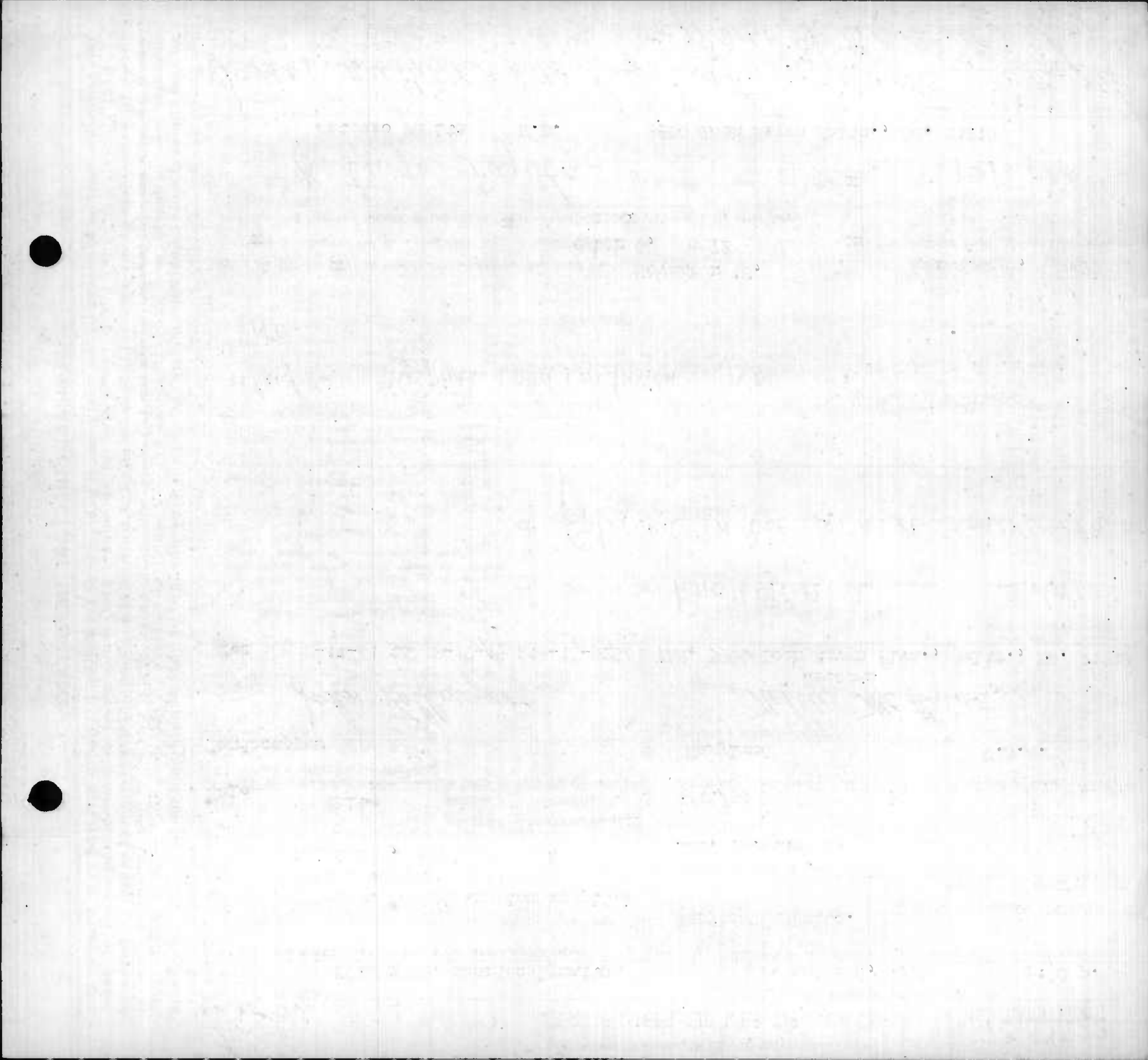
1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH		3. DATE PRONOUNCED DEAD		4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
LOUIS H. KALHOUN		Known <input type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year Hour		12 10 1972 9:35a		A. STATE Md. B. COUNTY 2664	
6. SEX male		7. RACE white		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. DATE OF BIRTH 3/28/'01		10. AGE (In years last birthday) 71 XX	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Louis Kalhoun		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ship's Master		15. MOTHER'S MAIDEN NAME Caroline Sherril	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes WWI		17. SOCIAL SECURITY NO. 217-74-5002		18. INFORMANT Piscataway, N.J. Mrs. Doris H. Reilly		19. CAUSE OF DEATH Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		Diabetes mellitus							
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12-11-72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/13/'72		24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. DEC 12 1972		25B. NAME OF REGISTRAR Sidney H. Weston		25C. FUNERAL DIRECTOR John A. Moran, Inc.		ADDRESS 3000 E. Baltimore St. Baltimore, Md. 21224			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

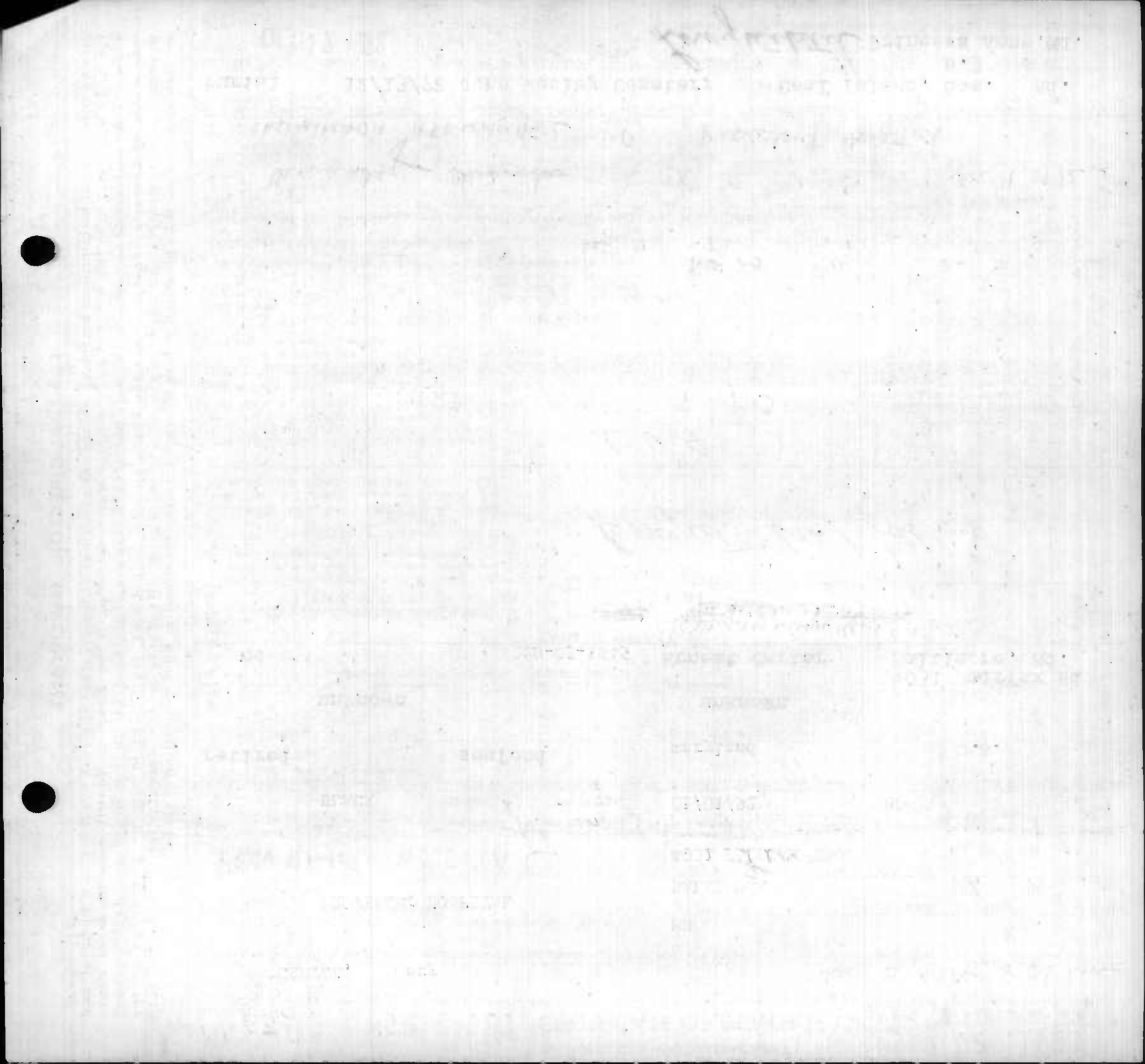
BALTIMORE CITY HEALTH DEPARTMENT				72 11722		72 11722	
BIRTH NO.				72 11722		STATE OF MARYLAND-DHMH	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
FOLLMAYER, Charles Ignaitus				December 6, 1972		9:00 p. M.	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				5. SEX		6. RACE	
A. STATE Maryland				Male		White	
B. COUNTY Balto.				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH	
C. CITY OR TOWN				WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		4/16/20	
D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				9. AGE (In years last birthday)		52	
E. STREET AND NUMBER				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
6617 Parsons Ave				Landscapper		Maryland	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
U.S.A.				John Follmeyer		Nellie McGuire	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
Yes				2-11-41 to 12-19-45		Records	
218-12-3264				VAH, 3900 Loch Raven Blvd., Balto., Md. 21218		ADDRESS	
18. CAUSE OF DEATH				19. DATE OF OPERATION		20. AUTOPSY? (Yes or No)	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				11/21/72		No	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				21. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (highly medical examined)		22. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
ANTECEDENT CAUSES				Dysphasia and Confusion			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				23. TIME OF INJURY (APPROX.)		24. WHERE DID INJURY OCCUR?	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				(Month) (Day) (Year) (Hour)		(If in Baltimore City, give exact location)	
Pneumonia				21. INJURY OCCURRED		25. HOW DID INJURY OCCUR?	
(B) Glioma in the brain				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
(C)				26. I certify that (X) (this hospital) attended the deceased from November 18, 1972 to December 6, 1972		27. DATE SIGNED	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				that (X) (we) last saw the deceased alive on December 6, 1972 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.		12/6/72	
19A. DATE OF OPERATION				23A. SIGNATURE		23B. DATE SIGNED	
11/21/72				Katsuzo Fujita		12/6/72	
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
Dysphasia and Confusion				Katsuzo Fujita M.D.		3900 Loch Raven Balto., Md. 21218	
20A. AUTOPSY? (Yes or No)				24. BURIAL CREMATION REMOVAL (Specify)		24B. DATE	
No				Burial Dec 9, 1972		24C. NAME OF CEMETERY OR CREMATORY	
21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				24D. LOCATION (City, town, or county)		(State)	
21C. WHERE DID INJURY OCCUR?				24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
(If in Baltimore City, give exact location)				DEC 12 1972		Frank A. Newell	
21E. INJURY OCCURRED				24G. NAME OF REGISTRAR		24H. FUNERAL DIRECTOR	
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				Frank A. Newell		24I. ADDRESS	
21F. HOW DID INJURY OCCUR?				24J. NAME OF REGISTRAR		24K. FUNERAL DIRECTOR	
				Frank A. Newell		24L. ADDRESS	
22. I certify that (X) (this hospital) attended the deceased from November 18, 1972 to December 6, 1972				24M. NAME OF REGISTRAR		24N. FUNERAL DIRECTOR	
that (X) (we) last saw the deceased alive on December 6, 1972 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.				24O. NAME OF REGISTRAR		24P. FUNERAL DIRECTOR	
23A. SIGNATURE				24Q. NAME OF REGISTRAR		24R. FUNERAL DIRECTOR	
Katsuzo Fujita				Frank A. Newell		24S. ADDRESS	
23C. PHYSICIAN'S NAME (Type)				24T. NAME OF REGISTRAR		24U. FUNERAL DIRECTOR	
Katsuzo Fujita M.D.				Frank A. Newell		24V. ADDRESS	
23D. ADDRESS				24W. NAME OF REGISTRAR		24X. FUNERAL DIRECTOR	
3900 Loch Raven Balto., Md. 21218				Frank A. Newell		24Y. ADDRESS	
24A. BURIAL CREMATION REMOVAL (Specify)				24Z. NAME OF REGISTRAR		25. DATE REC'D BY HEALTH DEPT.	
Burial Dec 9, 1972				Frank A. Newell		DEC 12 1972	
24B. DATE				25. NAME OF REGISTRAR		25. FUNERAL DIRECTOR	
24C. NAME OF CEMETERY OR CREMATORY				Frank A. Newell		25. ADDRESS	
24D. LOCATION (City, town, or county)				Frank A. Newell		25. ADDRESS	
(State)				Frank A. Newell		25. ADDRESS	
24E. DATE REC'D BY HEALTH DEPT.				25. NAME OF REGISTRAR		25. FUNERAL DIRECTOR	
DEC 12 1972				Frank A. Newell		25. ADDRESS	
24F. NAME OF REGISTRAR				25. NAME OF REGISTRAR		25. FUNERAL DIRECTOR	
Frank A. Newell				Frank A. Newell		25. ADDRESS	
24G. NAME OF REGISTRAR				25. NAME OF REGISTRAR		25. FUNERAL DIRECTOR	
Frank A. Newell				Frank A. Newell		25. ADDRESS	
24H. FUNERAL DIRECTOR				25. NAME OF REGISTRAR		25. FUNERAL DIRECTOR	
Frank A. Newell				Frank A. Newell		25. ADDRESS	
24I. ADDRESS				25. NAME OF REGISTRAR		25. FUNERAL DIRECTOR	
3900 Loch Raven Balto., Md. 21218				Frank A. Newell		25. ADDRESS	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">72 11723</span>	
C-636 72 11723				CERTIFICATE OF DEATH	
BIRTH NO. <span style="float: right;">72 11723</span>				STATE OF MARYLAND-DEATH	
1. NAME OF DECEASED (Type or Print) <b>CARTER, Mary</b>			2. DATE AND HOUR OF DEATH <b>Dec 9 1972 8:05 a.m.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>PROVIDENT HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>1509</b>		
5. SEX <b>F</b>			6. RACE <b>BLACK</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>01/01/92</b>			9. AGE (In years last birthday) <b>80</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>seafood</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			13. FATHER'S NAME <b>unknown</b>		
14. MOTHER'S MAIDEN NAME <b>unknown</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		
16. SOCIAL SECURITY NO. <b>220-05-1845</b>			17. INFORMANT <b>Ernest Carter</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>427.01</b> <b>Pulmonary edema and congestive heart failure</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> <b>CVA.</b>			20. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Congestive heart failure</b>		
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			22. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
23A. DATE OF OPERATION			23B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
24A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notly medical examiner)			24B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		
24C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			24D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		
24E. INJURY OCCURRED			24F. HOW DID INJURY OCCUR?		
24G. I certify that (I) (this hospital) attended the deceased from <b>Dec 29 1972</b> to <b>Dec 9 1972</b> , and that (I) (we) last saw the deceased alive on <b>Dec 9 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			24H. SIGNATURE <b>Hernandez, Minimada</b>		
24I. PHYSICIAN'S NAME (Type) <b>MINIMADA HERNANDEZ</b>			24J. ADDRESS <b>Provident Hospital</b>		
24K. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>			24L. DATE <b>12/13/72</b>		
24M. NAME OF CEMETERY OR CREMATORY <b>John Wesley Cemetery</b>			24N. LOCATION (City, town, or county) (State) <b>Deal Island, Som. Md.</b>		
24O. DATE REC'D BY HEALTH DEPT. <b>DEC 12 1972</b>			24P. NAME OF REGISTRAR <b>Princess Anne, Md.</b>		
24Q. FUNERAL DIRECTOR <b>R.3</b>			24R. ADDRESS <b>Princess Anne, Md.</b>		





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 11724	
G-656 72 11724				STATE OF MARYLAND-DEPT	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Gordon W. Garner</u>		2. DATE AND HOUR OF DEATH <u>Dec 8, 1972</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If Institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>604</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>35 Church Home &amp; Hospital</u>			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <u>201 N. Broadway</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/14/'17</u>	9. AGE (In years last birthday) <u>54</u>	10. Under 1 Yr. Months: Oys: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>cab Driver</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Sun Cab</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Thomas A. Garner</u>			14. MOTHER'S MAIDEN NAME <u>Elsie E. Grupp</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	17. INFORMANT <u>Mrs. Elsie Sherman 3202 E. Baltimore St</u>		
18. <u>3-19-3 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>chronic obstructive lung disease</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>on Nov 14</u> 19 <u>72</u> <u>to saw briefly Nov 19 72</u> that (I) (we) last saw the deceased alive on <u>Nov 30</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Mailee C.S. Cole MD</u>			23B. DATE SIGNED <u>Dec. 8, 1972</u>		23C. PHYSICIAN'S NAME (Type) <u>Mailee C.S. Cole</u>
23D. ADDRESS			23E. DATE REC'D BY HEALTH DEPT. <u>DEC 12 1972</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>12/11/'72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>			25A. FUNERAL DIRECTOR <u>John A. Moran, Inc.</u>		
25B. NAME OF REGISTRAR <u>John A. Moran, Inc.</u>			25C. ADDRESS <u>3000 E. Baltimore St.</u>		



1945

1. The first part of the report is a summary of the work done during the year.

2. The second part is a detailed account of the work done during the year.

3. The third part is a summary of the work done during the year.

4. The fourth part is a summary of the work done during the year.

5. The fifth part is a summary of the work done during the year.

6. The sixth part is a summary of the work done during the year.

7. The seventh part is a summary of the work done during the year.

8. The eighth part is a summary of the work done during the year.

9. The ninth part is a summary of the work done during the year.

10. The tenth part is a summary of the work done during the year.

11. The eleventh part is a summary of the work done during the year.

12. The twelfth part is a summary of the work done during the year.

13. The thirteenth part is a summary of the work done during the year.

14. The fourteenth part is a summary of the work done during the year.

15. The fifteenth part is a summary of the work done during the year.

16. The sixteenth part is a summary of the work done during the year.

17. The seventeenth part is a summary of the work done during the year.

18. The eighteenth part is a summary of the work done during the year.

19. The nineteenth part is a summary of the work done during the year.

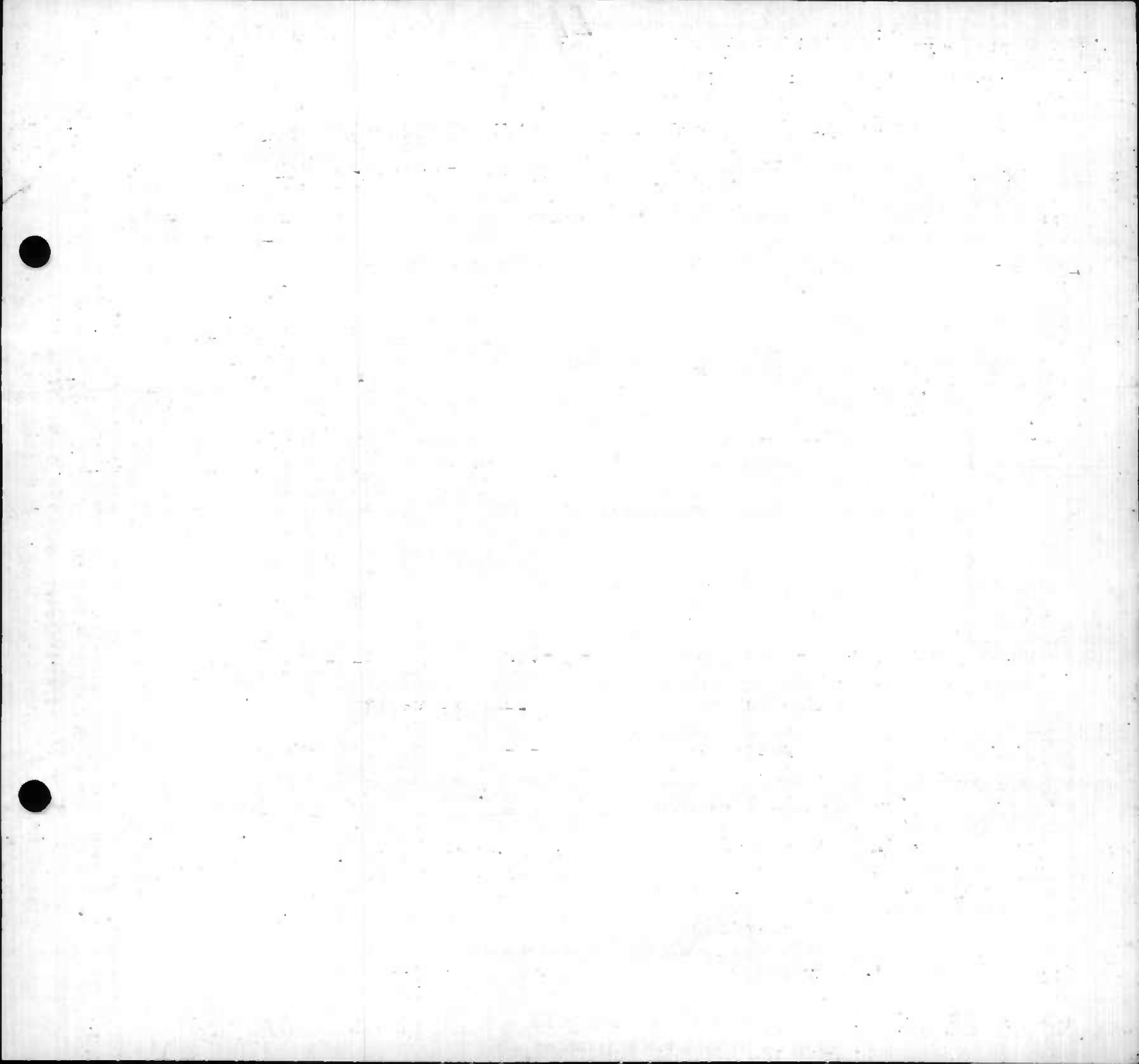
20. The twentieth part is a summary of the work done during the year.

21. The twenty-first part is a summary of the work done during the year.

# FUNERAL DIRECTOR: IMPORTANT

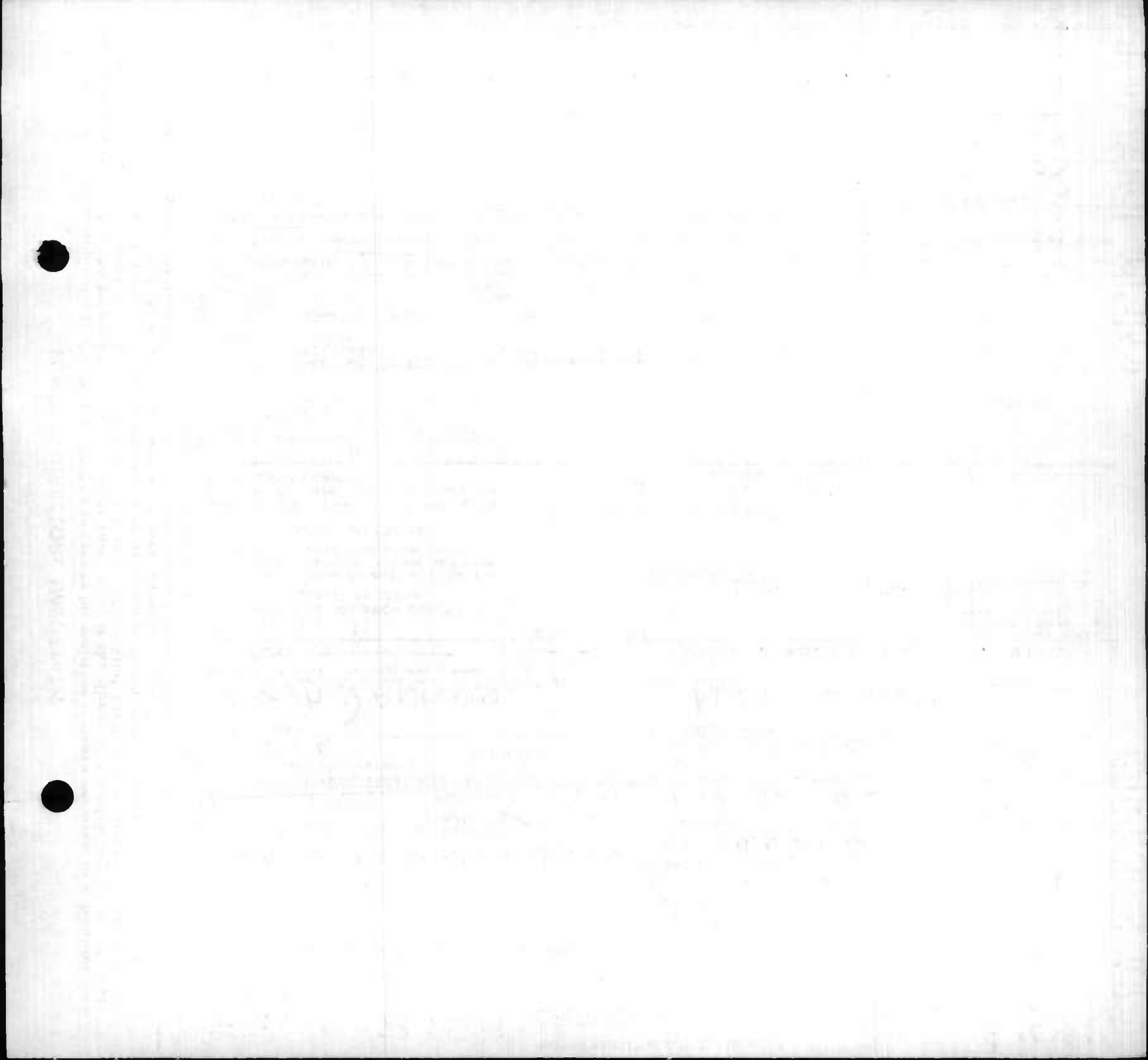
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-340		72 11725		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 11725	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		Lillian Lillian Staley		2. DATE AND HOUR OF DEATH December 9, 1972 7:30 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland		B. COUNTY 2714	
00 4204 Roland Avenue Baltimore, Maryland				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 4204 Roland Avenue			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 16, 1880	9. AGE (In years lost birthday) 92 yrs.	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME William Stevens		14. MOTHER'S MAIDEN NAME Laura Jones		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-74-8550	
		17. INFORMANT Ruth Staley-4204 Roland Avenue		ADDRESS			
18. 199.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinomatosis (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ?			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4-6 1972 to 12-9 1972, that (I) (we) last saw the deceased alive on 12-7 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Reuben Hoffman, M.D.		23B. DATE SIGNED 12-9-72		23C. PHYSICIAN'S NAME (Type) Reuben Hoffman, M.D.		23D. ADDRESS 846 West 36th Street	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/11/72		24C. NAME OF CEMETERY OR CREMATORY Wesley Chapel Cemetery		24D. LOCATION (City, town, or county) (State) Rock Hall 1, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 12 1972		25B. NAME OF REGISTRAR A. Alan Seitz, Jr.		25C. FUNERAL DIRECTOR A. Alan Seitz, Jr.		ADDRESS 3818 Roland Ave.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased deceased prior to death); and (6) No physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

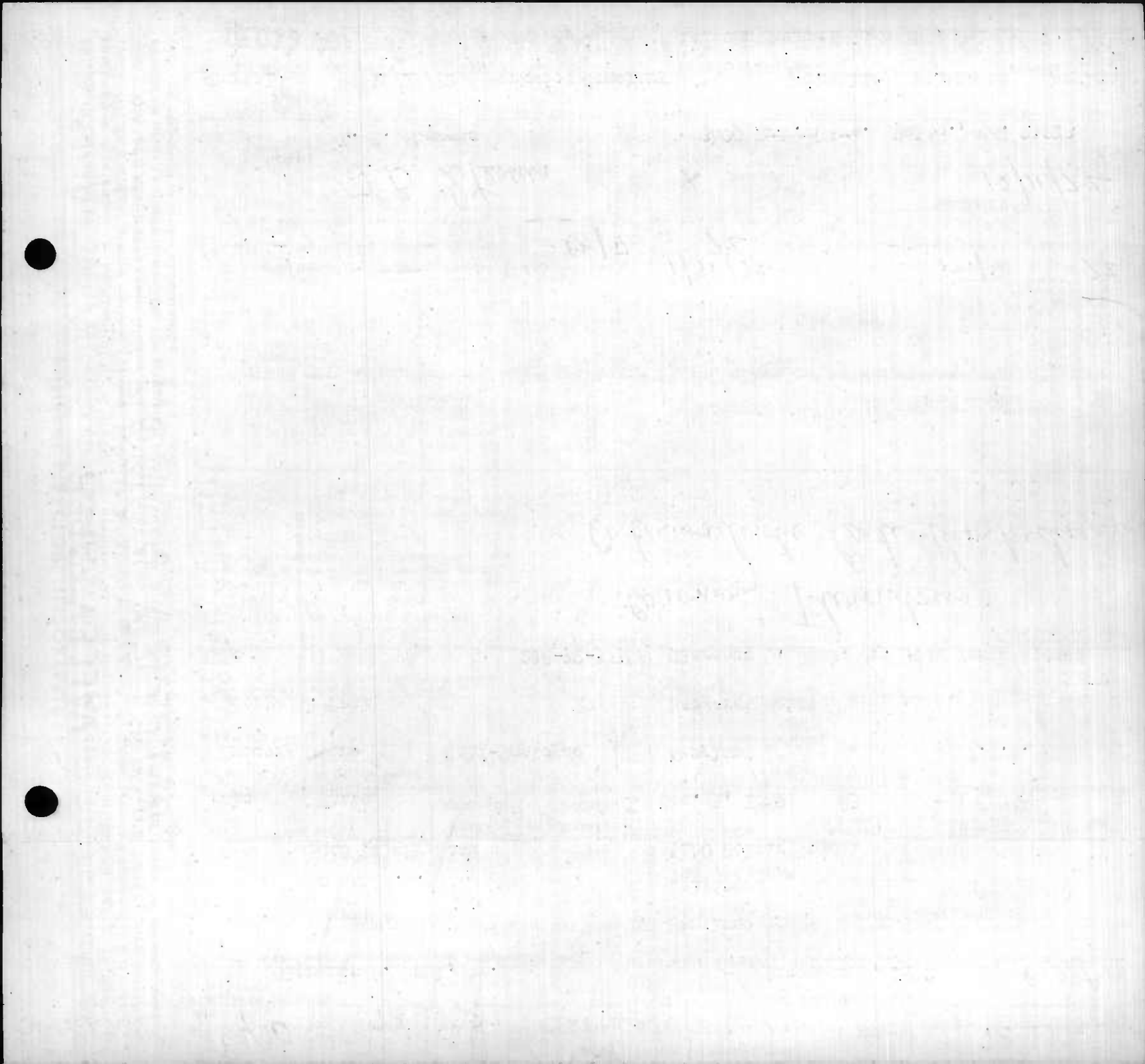
VS 150-REV. 1/1/68



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	72 11727
CERTIFICATE OF DEATH				STATE OF MARYLAND-DMH	
P-400 BIRTH NO. 72 11727		2. DATE AND HOUR OF DEATH December 8, 1972 6:30A M.			
1. NAME OF DECEASED (Type or Print) Clarence O. Paul, Sr.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 94 Layman N.H. 5440 Belair Road			
4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland C. CITY OR TOWN Baltimore E. STREET AND NUMBER 5440 Belair Road		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Dec. 3, 1889	9. AGE (In years last birthday) 83	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocery Store
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocery Store		10B. KIND OF BUSINESS OR INDUSTRY Self-Employed		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME George W. Paul		14. MOTHER'S MAIDEN NAME Margaret Weiss			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-32-3938A		17. INFORMANT ADDRESS 21234 Clarence O. Paul, Jr. 3212 Texas Avenue	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. I Coronary Thrombosis Arteriosclerotic Cardio-Vascular disease		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II 19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____ 20A. AUTOPSY? (Yes or No) _____ 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1/31/72 19 to 12/8 1972, that (I) (we) lost saw the deceased alive on 12/7 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE L.B. Stevens		23B. DATE SIGNED 12/11/72		23C. PHYSICIAN'S NAME (Type) L. B. Stevens	
23D. ADDRESS 3400 Erdman Ave. Balto., Md. 21213		24. NAME OF CEMETERY or CREMATORY Parkwood Cemetery			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/11/72		24C. LOCATION (City, town, or county) Parkville Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 12 1972		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS 21236 Lassahn Funeral Home 7401 Belair Rd. Balto.	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

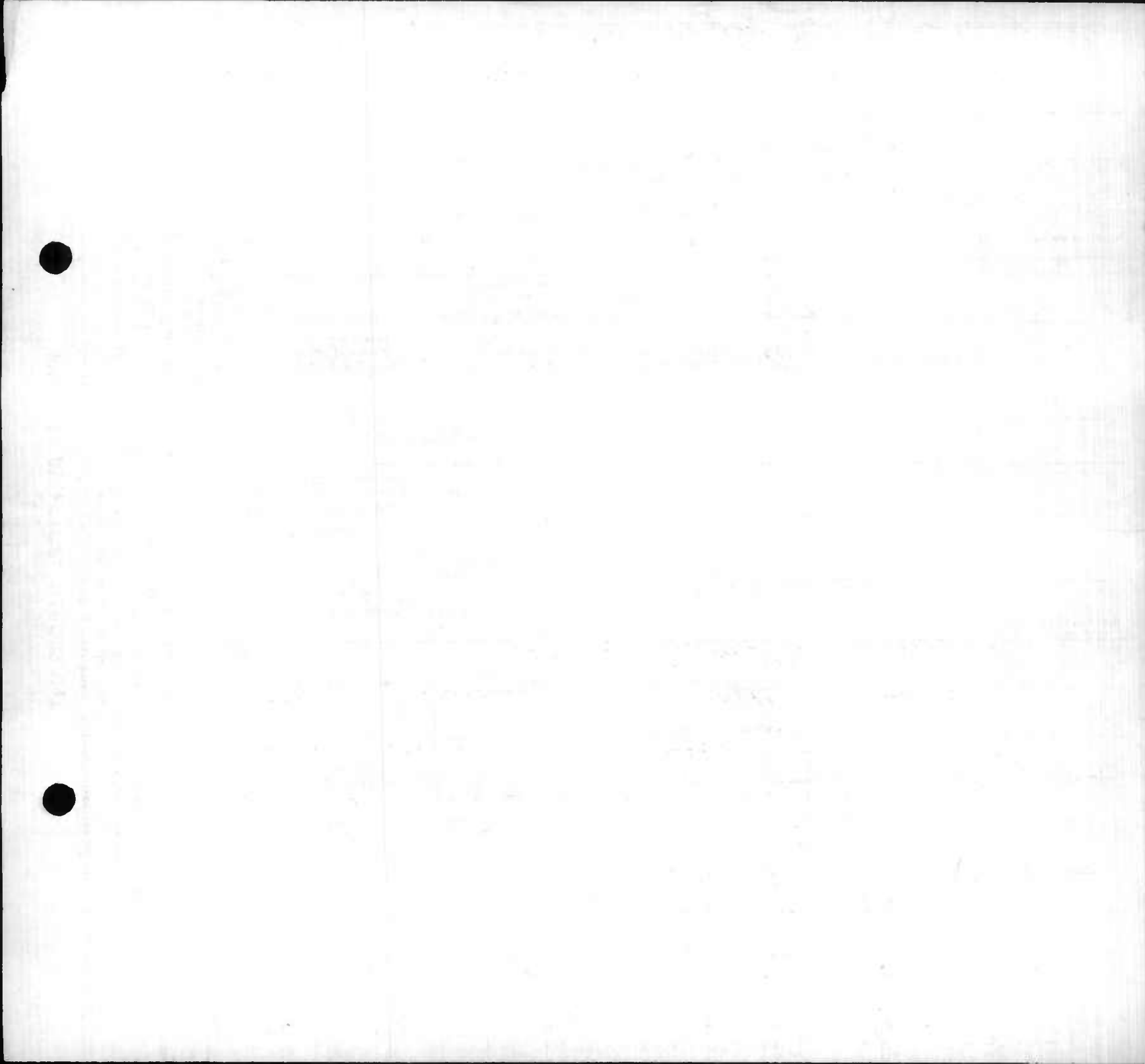
BALTIMORE CITY HEALTH DEPARTMENT				72 11728		REG. NO.	
Y-240				72 11728		STATE OF MARYLAND-DIME	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>CLIFFORD YEAGLEY</i>				2. DATE AND HOUR OF DEATH <i>12/9 8:15 AM</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>THE JOHNS HOPKINS HOSPITAL</i> <i>33 BALTIMORE, MD 21205</i>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>BALTO</i> C. CITY OR TOWN <i>BALTO</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>438 BLAKE RD</i>			
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8/04/27</i>		9. AGE (In years last birthday) <i>45</i>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>STEEL WORKER</i>				11. BIRTHPLACE (State or foreign country) <i>BALTO</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>CLIFFORD YEAGLEY</i>				14. MOTHER'S MAIDEN NAME <i>MARIE DETLOFF</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>YES WWII</i>				16. SOCIAL SECURITY NO. <i>215-22-3717</i>		17. INFORMANT <i>MELLIE YEAGLEY</i> ADDRESS <i>ABOVE</i>	
18. <i>199.0 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>dissected aorta</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>renal failure</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>possible infection</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 yr.</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>12/2 1972</i> to <i>12/9 1972</i> , that (I) (we) last saw the deceased alive on <i>12/9 1972</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Lam. H. Massey MD</i>				23B. DATE SIGNED <i>12/9/72</i>		23C. PHYSICIAN'S NAME (Type) <i>LAMAS H. MASSEY MD</i>	
23D. ADDRESS <i>JOHNS HOPKINS</i>				24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>			
24B. DATE <i>12/12/72</i>		24C. NAME OF CEMETERY OR CREMATORY <i>GARDENS OF FAITH</i>		24D. LOCATION (City, town, or county) (State) <i>BALTO. MD.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 12 1972</i>		25B. NAME OF REGISTRAR <i>A. J. Connelly</i>		25C. FUNERAL DIRECTOR <i>J. G. CONNELLY</i> ADDRESS <i>300 MACE</i>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

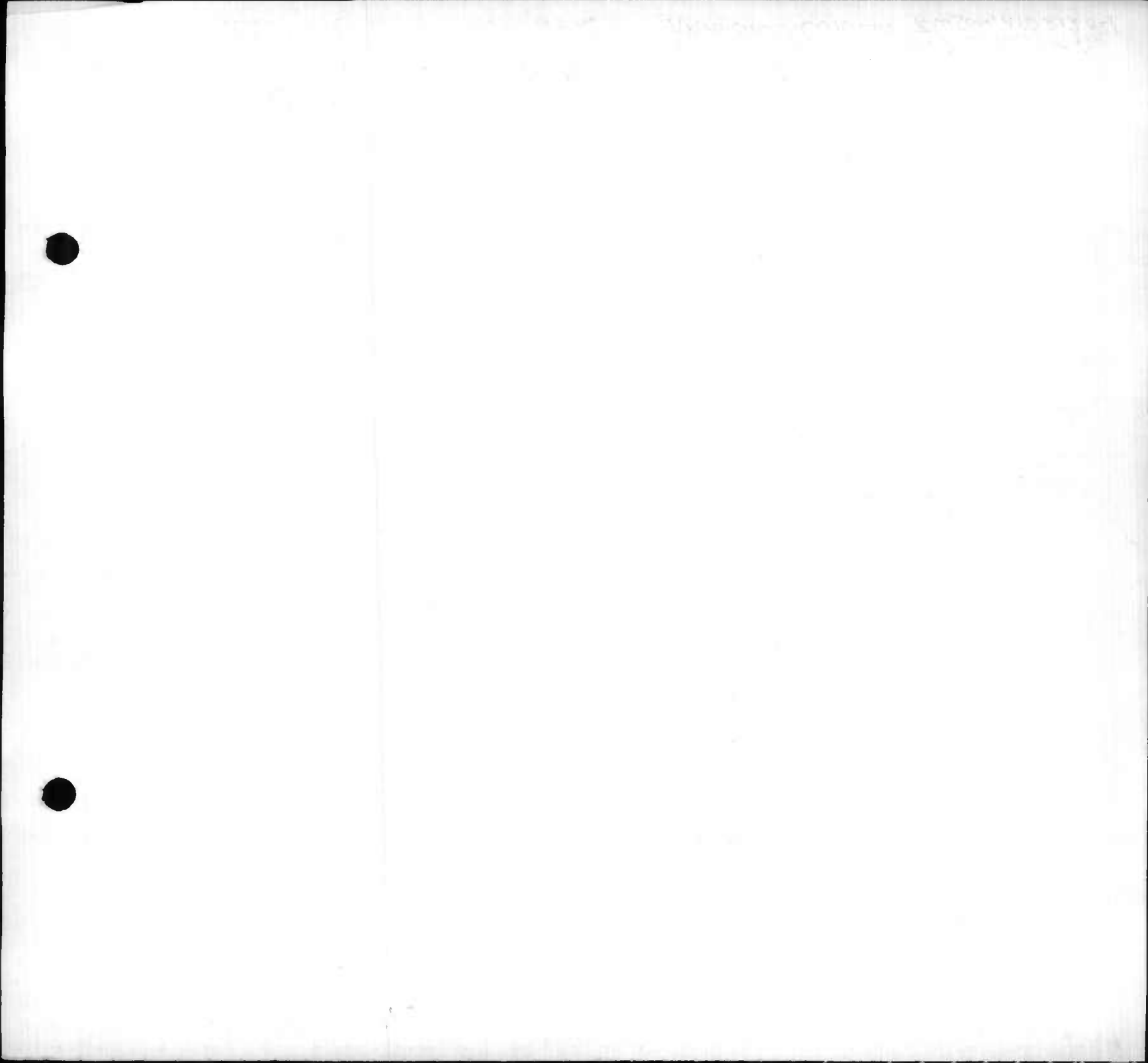
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 11729	
M-324 72 11729				STATE OF MARYLAND - DEPT.	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Mitchell, Thomas H.			12-9-72 1:35 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			M.D. 1203		
44 THE UNION MEMORIAL HOSPITAL.			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			432 E. 28th Street		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
MALE	WHITE		3-11-10	67	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
FACTORY WORKER			PENNSYLVANIA		U.S.A. AMERICAN
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
HARRY MITCHELL			MARY LOCKE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
No			208-07-5314		CALEFFIE-GREENLIEF FUNERAL HOME
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			Diphtheria 8 days		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Takeshi Kuba M.D.				12-9-72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
				UNION Memorial Hospital 33rd and Calvert St. Balto. M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
BURIAL		12-12-72		HOLLINS Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
DEC 12 1972		Audrey Anderson		Wm. Locke Brooks Towson, Inc. Towson, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 11730		REG. NO. 72 11730	
W-452				72 11730		STATE OF MARYLAND - DEPT	
1. NAME OF DECEASED (Type or Print) <b>Gertrude Williams</b>				2. DATE AND HOUR OF DEATH <b>3:50 PM 12/4/72</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>UNIVERSITY of Maryland Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>Springfield State Hosp</b>			
				C. CITY OR TOWN <b>UNKNOWN</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>UNKNOWN 5600</b>			
5. SEX <b>F</b>	6. RACE <b>B</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>UNKNOWN</b>	9. AGE (In years last birthday) <b>69</b>	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>UNKNOWN</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>UNKNOWN</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>		17. INFORMANT <b>Char t</b>		ADDRESS	
18. CAUSE OF DEATH <b>56991</b>				DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cardio-pulmonary arrest</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 min.</b>	
				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Hypovolemia + Shock</b>		<b>3 min.</b>	
				(B) DUE TO, OR AS A CONSEQUENCE OF: <b>ACUTE UGI bleed.</b>		<b>24 hrs.</b>	
				(C) <b>Thoracic Aneurysm</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <b>12/4/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Locate Bleedy</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? <input type="checkbox"/>		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) <b>0</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>0</b>			
22. I certify that (I) (this hospital) attended the deceased from <b>12/4/72 10:00 AM</b> to <b>3:50 PM 12/4/72</b> that (I) (we) last saw the deceased alive on <b>12/4/72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Louis C. Kanell</b>				23B. DATE SIGNED <b>12/4/72</b>		23C. PHYSICIAN'S NAME (Type) <b>Raymond C. Curran</b>	
23D. ADDRESS <b>817 SCARLETT DR TOWSON, MD 21204</b>				23E. FUNERAL DIRECTOR <b>Raymond C. Curran</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>12/11/72</b>		24B. DATE <b>12/11/72</b>		24C. NAME of CEMETERY or CREMATORY <b>VOF M Anatomy Board</b>		24D. LOCATION (City, town, or county) (State) <b>Balt, Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 12 1972</b>		25B. NAME OF REGISTRAR <b>Louis C. Kanell</b>		25C. FUNERAL DIRECTOR <b>Raymond C. Curran</b>		25D. ADDRESS <b>817 SCARLETT DR TOWSON, MD 21204</b>	

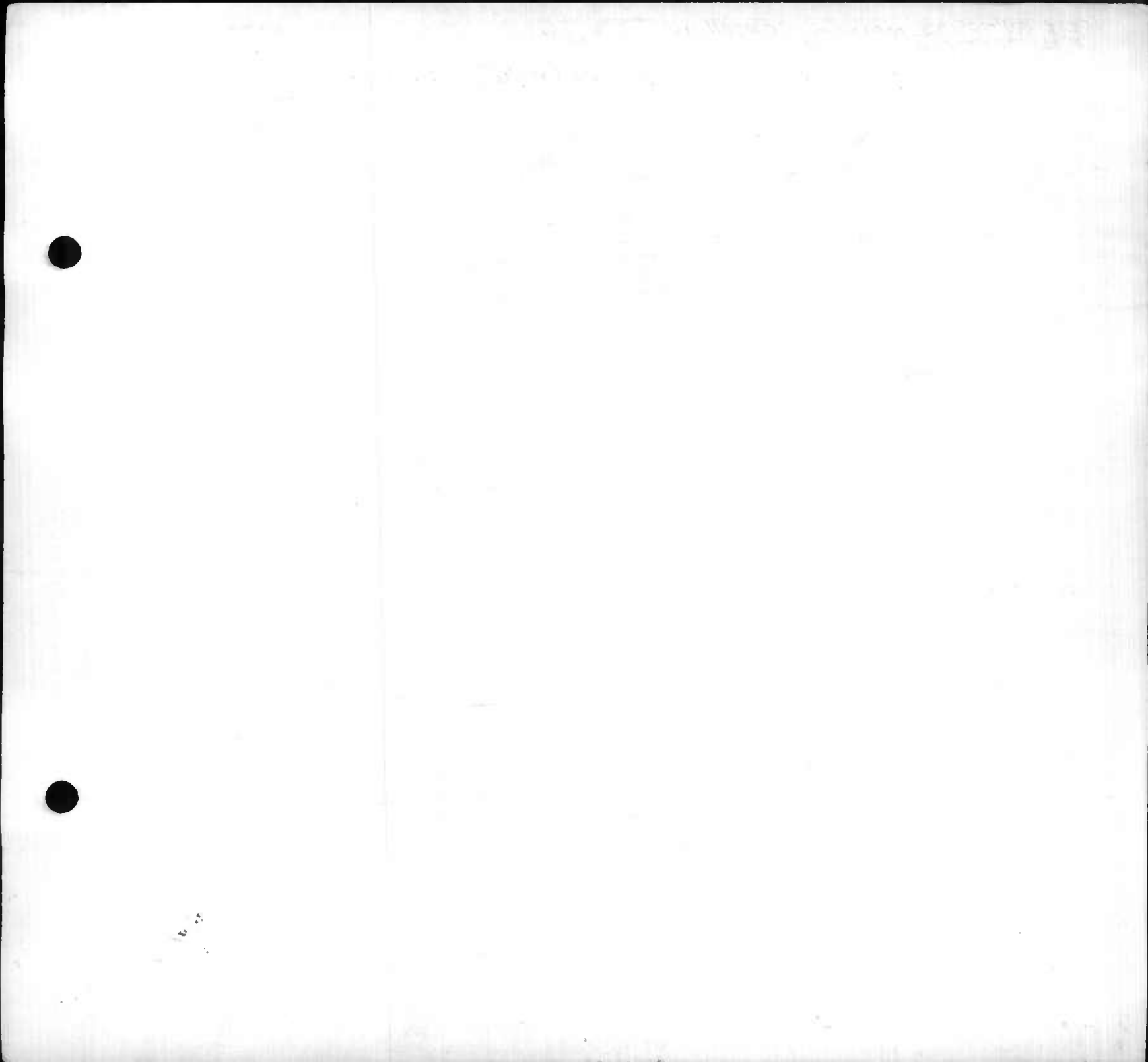


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<b>BALTIMORE CITY HEALTH DEPARTMENT</b> <b>CERTIFICATE OF DEATH</b>		REG. NO. <u>72 11731</u> STATE OF MARYLAND - <u>DEWITT</u>	
BIRTH NO. <u>BC177483</u> 1. NAME OF DECEASED (Type or Print) <u>Baby Girl Zantt</u>		2. DATE AND HOUR OF DEATH <u>Nov 21, 1972</u> <u>4:30 AM</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>University of Maryland</u> <u>38 Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>BALTO</u> C. CITY OR TOWN <u>Severna Park</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>Box 850 RT I</u>	
5. SEX <u>F</u> 6. RACE <u>Black</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 21, 1972</u> 9. AGE (in years last birthday) <u>1</u> <u>30</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James Zantt</u>		14. MOTHER'S MAIDEN NAME <u>Alma Jones</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Alma Zantt</u>	17. INFORMANT <u>Alma Zantt</u>
18. <u>777X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>PREMATURITY</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Pre maturity</u> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hr. 30 min.</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>2</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>		(If in Baltimore City, give exact location)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>Nov 21 3:00 PM 1972</u> to <u>Nov 21 4:30 AM 1972</u> that (I) (we) last saw the deceased alive on <u>Nov. 21, 4:30 AM 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Neil E. Ashman M.D.</u>		23B. DATE SIGNED <u>Nov. 21, 1972</u>	
23C. PHYSICIAN'S NAME (Type) <u>Gail E. Ashman M.D.</u>		23D. ADDRESS <u>University of Maryland Hospital</u>	
24A. BURIAL (CREMATION) REMOVAL (specify) <u>12/1/72</u>	24B. DATE <u>12/1/72</u>	24C. NAME of CEMETERY or CREMATORY <u>166th ANATOMY BOARD</u>	24D. LOCATION (City, town, or county) (State) <u>BALTO, MD</u>
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 12 1972</u>		25B. NAME OF REGISTRAR <u>Sidney Whorton</u>	
25C. FUNERAL DIRECTOR <u>RAYMOND J. CURRAN</u>		ADDRESS <u>877 S. CARLETT DR. RUSSELL, MD. 21274</u>	





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 11732

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>ANDERSON FRANKLIN SPENCE</b> <b>Sponsor Anderson</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 11 10 72 12:50 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>CERTIFICATE AMENDED</b> <b>Mercy Hospital</b> <b>6/2/73</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour 11 10 72 12:50 P.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH <b>UNKNOWN</b>		10. AGE (In years lost birthday) 60	
11. BIRTHPLACE (State or foreign country) <b>UNKNOWN</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>UNKNOWN</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>UNKNOWN</b>	
15. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO. <b>UNK.</b>		18. INFORMANT <b>MEDICAL EXAMINER'S OFFICE</b>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2/11/72</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>W P Mulloy</b> M.D. EXAMINER'S NAME (Type) <b>William P. Mulloy, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>11-11-72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>12-11-72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>NOEM Anatomy Board</b>		24D. LOCATION (City, town, or county) (State) <b>Balt. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 12 1972</b>		25B. NAME OF REGISTRAR <b>Audrey Johnston</b>	
25C. FUNERAL DIRECTOR <b>RAYMOND J. CURRAN</b>		25D. ADDRESS <b>8175 CARLETON DR TOWSON, MD. 21204</b>	

6/12/73 - Letter from Assistant Medical Examiner, William P. Mulloy, M.D.,  
6/8/73. *WPC.*

C-462		72 11733		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. 72 11733	
BIRTH NO.									
1. NAME OF DECEASED (Type or Print) Edna Clark					2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 11 3 72 11:50A.M.				
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 407 Park Avenue					3. DATE PRONOUNCED DEAD Month Day Year Hour 11 3 72 11:50A.M.				
5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 401									
6. SEX Female		7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH UNKNOWN		10. AGE (In years last birthday) 63		11. BIRTHPLACE (State or foreign country) UNKNOWN		12. CITIZEN OF WHAT COUNTRY? U.S.		E. STREET AND NUMBER 407 Park Avenue	
13. FATHER'S NAME UNKNOWN		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN		15. MOTHER'S MAIDEN NAME UNKNOWN		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. UNK	
18. INFORMANT MEDICAL EXAMINERS OFFICE		19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		20. DATE OF OPERATION 0		21. AUTOPSY? (Yes or No) No		22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		24. BURIAL CREMATION REMOVAL (Specify)		25. DATE 12/11/72		26. NAME OF CEMETERY or CREMATORY UORM ANATOMY BOARD		27. LOCATION (City, town, or county) (State) BALT. MD.	
28. TIME (Month) (Day) (Year) (Hour) (APPROX.)		29. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		30. HOW DID INJURY OCCUR?		31. DATE REC'D BY HEALTH DEPT. DEC 12 1972		32. NAME OF REGISTRAR Arony Ingham	
33. ACTUAL SIGNATURE EXAMINER'S NAME (Type) William P. Milloy, M.D.		34. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		35. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		36. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		37. DATE SIGNED 11-3-72	
38. FUNERAL DIRECTOR RAYMOND J. CUREN		39. ADDRESS 8125 SCARLETON DR TOWSON, MD 21204		40. 25A. DATE REC'D BY HEALTH DEPT. DEC 12 1972		41. 25B. NAME OF REGISTRAR Arony Ingham		42. 25C. FUNERAL DIRECTOR RAYMOND J. CUREN	

1945  
1946  
1947  
1948  
1949  
1950  
1951  
1952  
1953  
1954  
1955  
1956  
1957  
1958  
1959  
1960  
1961  
1962  
1963  
1964  
1965  
1966  
1967  
1968  
1969  
1970  
1971  
1972  
1973  
1974  
1975  
1976  
1977  
1978  
1979  
1980  
1981  
1982  
1983  
1984  
1985  
1986  
1987  
1988  
1989  
1990  
1991  
1992  
1993  
1994  
1995  
1996  
1997  
1998  
1999  
2000  
2001  
2002  
2003  
2004  
2005  
2006  
2007  
2008  
2009  
2010  
2011  
2012  
2013  
2014  
2015  
2016  
2017  
2018  
2019  
2020  
2021  
2022  
2023  
2024  
2025

1945  
1946  
1947  
1948  
1949  
1950  
1951  
1952  
1953  
1954  
1955  
1956  
1957  
1958  
1959  
1960  
1961  
1962  
1963  
1964  
1965  
1966  
1967  
1968  
1969  
1970  
1971  
1972  
1973  
1974  
1975  
1976  
1977  
1978  
1979  
1980  
1981  
1982  
1983  
1984  
1985  
1986  
1987  
1988  
1989  
1990  
1991  
1992  
1993  
1994  
1995  
1996  
1997  
1998  
1999  
2000  
2001  
2002  
2003  
2004  
2005  
2006  
2007  
2008  
2009  
2010  
2011  
2012  
2013  
2014  
2015  
2016  
2017  
2018  
2019  
2020  
2021  
2022  
2023  
2024  
2025

1945  
1946  
1947  
1948  
1949  
1950  
1951  
1952  
1953  
1954  
1955  
1956  
1957  
1958  
1959  
1960  
1961  
1962  
1963  
1964  
1965  
1966  
1967  
1968  
1969  
1970  
1971  
1972  
1973  
1974  
1975  
1976  
1977  
1978  
1979  
1980  
1981  
1982  
1983  
1984  
1985  
1986  
1987  
1988  
1989  
1990  
1991  
1992  
1993  
1994  
1995  
1996  
1997  
1998  
1999  
2000  
2001  
2002  
2003  
2004  
2005  
2006  
2007  
2008  
2009  
2010  
2011  
2012  
2013  
2014  
2015  
2016  
2017  
2018  
2019  
2020  
2021  
2022  
2023  
2024  
2025

1945  
1946  
1947  
1948  
1949  
1950  
1951  
1952  
1953  
1954  
1955  
1956  
1957  
1958  
1959  
1960  
1961  
1962  
1963  
1964  
1965  
1966  
1967  
1968  
1969  
1970  
1971  
1972  
1973  
1974  
1975  
1976  
1977  
1978  
1979  
1980  
1981  
1982  
1983  
1984  
1985  
1986  
1987  
1988  
1989  
1990  
1991  
1992  
1993  
1994  
1995  
1996  
1997  
1998  
1999  
2000  
2001  
2002  
2003  
2004  
2005  
2006  
2007  
2008  
2009  
2010  
2011  
2012  
2013  
2014  
2015  
2016  
2017  
2018  
2019  
2020  
2021  
2022  
2023  
2024  
2025

BALTIMORE CITY HEALTH DEPARTMENT									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
BIRTH NO.					REG. NO.				
1. NAME OF DECEASED (Type or Print) Frances Leissille					2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 11 10 72 9:30A. M.				
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 227 S. Broadway					3. DATE PRONOUNCED DEAD Month Day Year Hour 11 10, 72 9:30 A. M.				
6. SEX Male					7. RACE White				
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					C. CITY OR TOWN Baltimore				
9. DATE OF BIRTH UNKNOWN					10. AGE (In years lost birthday) 68				
11. BIRTHPLACE (State or foreign country) UNKNOWN					12. CITIZEN OF WHAT COUNTRY? U.S.				
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN					14B. KIND OF BUSINESS OR INDUSTRY UNKNOWN				
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)					17. SOCIAL SECURITY NO. UNK.				
18. INFORMANT MEDICAL EXAMINERS OFFICE					ADDRESS MEDICAL EXAMINERS OFFICE				
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
20A. DATE OF OPERATION 0									
20B. CONDITION FOR WHICH OPERATION WAS PERFORMED									
21. AUTOPSY? (Yes or No) No									
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?					22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					22F. HOW DID INJURY OCCUR?				
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <i>W P Mulloy</i> M.D. EXAMINER'S NAME (Type): William P. Mulloy, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: 11-10-72									
24A. BURIAL CREMATION, REMOVAL (Specify)					24B. DATE 12-11-72				
24C. NAME OF CEMETERY or CREMATORY U of A Anatomy Board					24D. LOCATION (City, town, or county) (State) Balt. Md.				
25A. DATE REC'D BY HEALTH DEPT. DEC 12 1972					25B. NAME OF REGISTRAR Andrew Johnston				
25C. FUNERAL DIRECTOR Raymond J. Curran					ADDRESS 817 CHARLETT DR. TOWSON, MD 21204				





72 11735

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 11735

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Richard Stone</b>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month <b>11</b> Day <b>7</b> Year <b>72</b> Hour <b>M.</b> Estimated <input type="checkbox"/>			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>10 E. Cross Street</b>				3. DATE PRONOUNCED DEAD Month <b>11</b> Day <b>7</b> Year <b>72</b> Hour <b>5:30 p.</b> M.			
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2302</b>							
6. SEX <b>male</b>		7. RACE <b>White</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>UNKNOWN</b>		10. AGE (In years last birthday) <b>51</b>		11. BIRTHPLACE (State or foreign country) <b>UNKNOWN</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>UNKNOWN</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>UNKNOWN</b>		15. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. <b>UNKNOWN</b>		18. INFORMANT <b>EXAMINERS OFFICE</b>		ADDRESS	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Fatty metamorphosis of liver</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Arteriosclerotic cardiovascular disease</b>							
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) <b>yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Peter Lipkovic, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Peter Lipkovic, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>11/8/72</b>							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>12/11/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>COFM ANTHONY BOARD</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO. MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 12 1972</b>		25B. NAME OF REGISTRAR <b>Audrey Johnson</b>		25C. FUNERAL DIRECTOR <b>Raymond Curran</b>		ADDRESS <b>8175 CARLETT DR DULSON, MD 21047</b>	

1944-1945

1946-1947

1948-1949

1950-1951

1952-1953

1954-1955

1956-1957

1958-1959

1960-1961

1962-1963

1964-1965

1966-1967

1968-1969

1970-1971

1972-1973

1974-1975

1976-1977

1978-1979

1980-1981

1982-1983

1984-1985

1986-1987

1988-1989

1990-1991

1992-1993

1994-1995

1996-1997

1998-1999

2000-2001

2002-2003

2004-2005

2006-2007

2008-2009

2010-2011

2012-2013

2014-2015

2016-2017

2018-2019

2020-2021

2022-2023

2024-2025

2026-2027

2028-2029

2030-2031

2032-2033

2034-2035

2036-2037

2038-2039

2040-2041

2042-2043

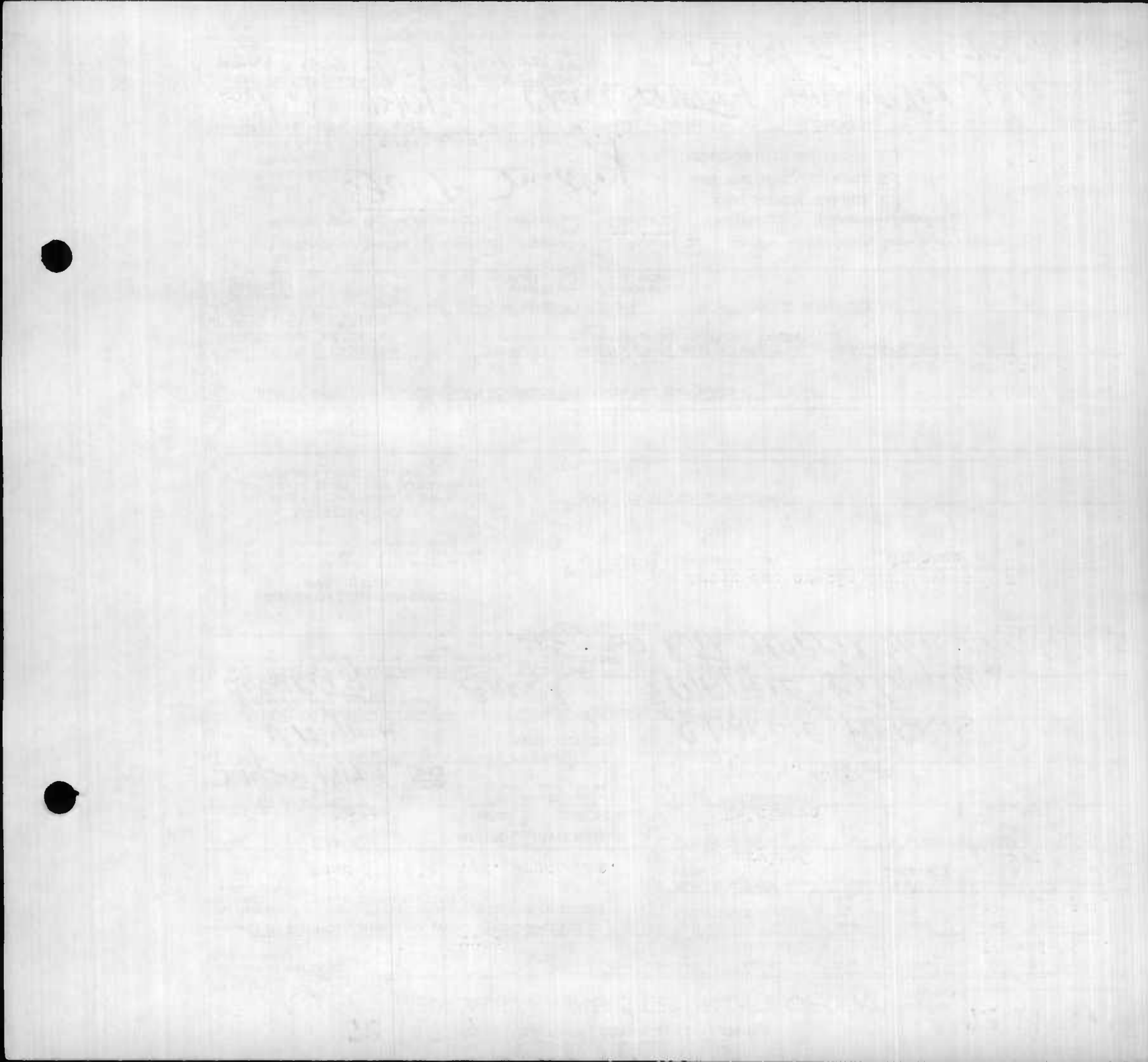
2044-2045

2046-2047

2048-2049

2050-2051

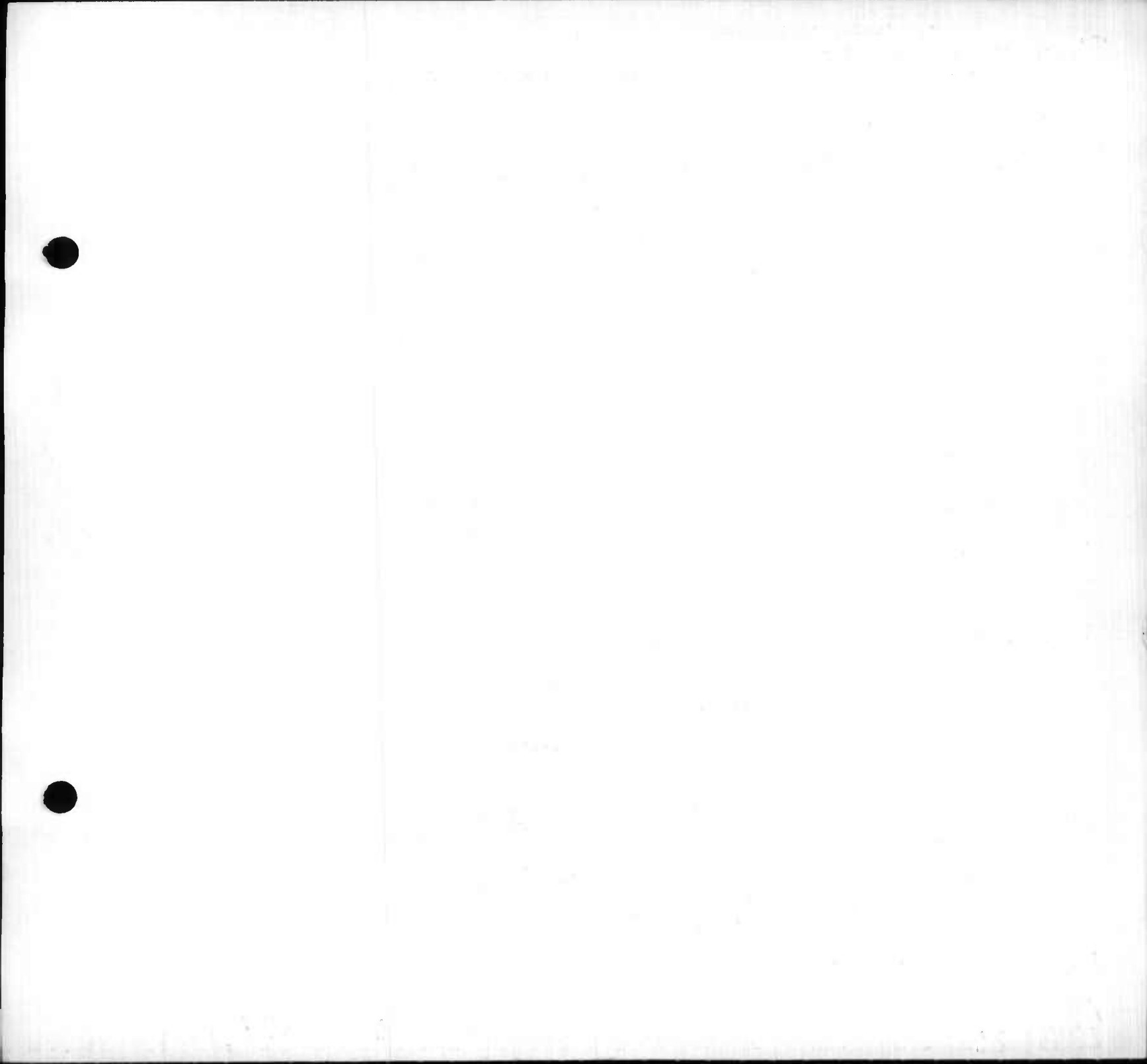
H-620		72 11736		STATE OF MARYLAND - DEPT. OF HEALTH BALTIMORE CITY HEALTH DEPARTMENT		72 11736	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH						REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>William Harris</b>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 12 9 72 5:05 A. M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 Rear 500 blk N. E. North Ave.</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour 12 9 72 5:05 A. M.			
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>USA 802</b>				C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
6. SEX <b>Male</b>	7. RACE <b>Negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER <b>1600 N. Bradford</b>			
9. DATE OF BIRTH <b>July 25 1914</b>		10. AGE (in years last birthday) <b>58</b>		11. BIRTH PLACE (State or foreign country) <b>VIETNAM</b>			
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>CHARLIE HARRIS</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SECURITY</b>			
15. MOTHER'S MAIDEN NAME <b>MAMIE FITZGERALD</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. <b>218-03-7643</b>		18. INFORMANT ADDRESS <b>RUTH HARRIS 1600 N. BRADFORD ST</b>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(A) IMMEDIATE CAUSE <b>Arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ (C) _____			
20A. DATE OF OPERATION <b>2</b>				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) <b>Yes</b>				22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Min.)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22F. HOW DID INJURY OCCUR?				23.			
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>W P Mulloy</b> EXAMINER'S NAME (Type) <b>William P. Mulloy, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
DATE SIGNED <b>12-9-72</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12/13/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>CHURCH CEMETERY</b>		24D. LOCATION (City, town, or county) (State) <b>APPA MATTOT VA</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 12 1972</b>		25B. NAME OF REGISTRAR <b>Andrew Johnson</b>		25C. FUNERAL DIRECTOR <b>DONALD E. GLWER</b>		ADDRESS <b>712 E. NORTH AVE</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-420		72 11737		BALTIMORE CITY HEALTH DEPARTMENT		72 11737	
<b>CERTIFICATE OF DEATH</b>				REG. NO. <b>STATE OF MARYLAND-DHMH</b>			
1. NAME OF DECEASED (Type or Print) <u>William G. Polk</u>				2. DATE AND HOUR OF DEATH <u>12/11/72</u> <u>12:50 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>1501 N. <del>Pulaski</del> Pulaski St.</u> <u>Baltimore, Md. 21217</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1502</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1501 N. Pulaski St.</u>			
5. SEX <u>M</u>	6. RACE <u>B</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/9/05</u>	9. AGE (In years last birthday) <u>67</u>	10. Under 1 Yr. <input type="checkbox"/> 11. Under 24 Hrs. <input type="checkbox"/> Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Physician</u>		11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME <u>Lillie</u>			
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <u>Yes</u> <u>1943-1946</u>		16. SOCIAL SECURITY NO. <u>212-28-3326</u>		17. INFORMANT <u>Helen Polk (wife)</u>		ADDRESS <u>same address</u>	
18. CAUSE OF DEATH <u>410.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  19A. DATE OF OPERATION <u>None</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>None</u> 20A. AUTOPSY? (Yes or No) <u>No</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <u>None</u> 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  21D. TIME OF INJURY (APPROX.) <u>None</u> 21E. INJURY OCCURRED <u>None</u> 21F. HOW DID INJURY OCCUR?  22. I certify that (I) (this hospital) attended the deceased from <u>12/11</u> 19 <u>72</u> to <u>12/11</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>12/11</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) ( <del>did not</del> ) view the body after death.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Less than 10 minutes</u> <u>cause unknown</u>			
23A. SIGNATURE <u>D. W. Stewart, M.D.</u>				23B. DATE SIGNED <u>12/11/72</u>		23C. PHYSICIAN'S NAME (Type) <u>D. W. STEWART, M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>12-13-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Auburn Cemetery</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 12 1972</u>				25B. NAME OF REGISTRAR <u>Audrey Whitman</u>		25C. FUNERAL DIRECTOR <u>4101 Edmondson Ave. #229</u> <u>Marshall W. Jones, Jr.</u>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
C-200		72 11738		72 11738	
<div style="display: flex; justify-content: space-between;"> <span>BIRTH NO.</span> <span>CERTIFICATE OF DEATH</span> <span>STATE OF MARYLAND-DEMENT</span> </div>					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
LAWRENCE COOK (COOKE)			12-8-72		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION			A. STATE		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			B. COUNTY		
34 BON SECOURS HOSPITAL			MARYLAND		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			2721 Fairmount Avenue		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months: Days: Hours: Min.
XXXXX M.	Black	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8/12/1915	57	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
Laborer		W.R. GRACE & CO.		U.S.A.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Grady Cook			Maggie Cook		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No.		215-22-8295		Mrs. Winfred Cook	
				2721 Fairmount Ave.	
18. CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			(A) IMMEDIATE CAUSE		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			Myocardial Infarction		
ANTECEDENT CAUSES			DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) Hypertensive cardiovascular disease		
			(C) Hypertension		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 5-28 1970 to 11-7 1972, that (I) (we) last saw the deceased alive on 11-7 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
John J. Chissell, MD				12-11-72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
John T. Chissell MD				940 W. North Ave Baltimore MD 21217	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		12/13/72		New Zion Bapt. Ch. Cem.	
				Bennettsville, S.C.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
DEC 12 1972		[Signature]		MORTON & DYETT F.H.	
				1701 Laurens Street	



DEPT. STATE

1914

1914

1914

1914

DEPT. STATE

DEPT. STATE

1914-15

1914-15

1914-15

1914-15

1914-15

1914-15

1914-15

1914-15

1914-15

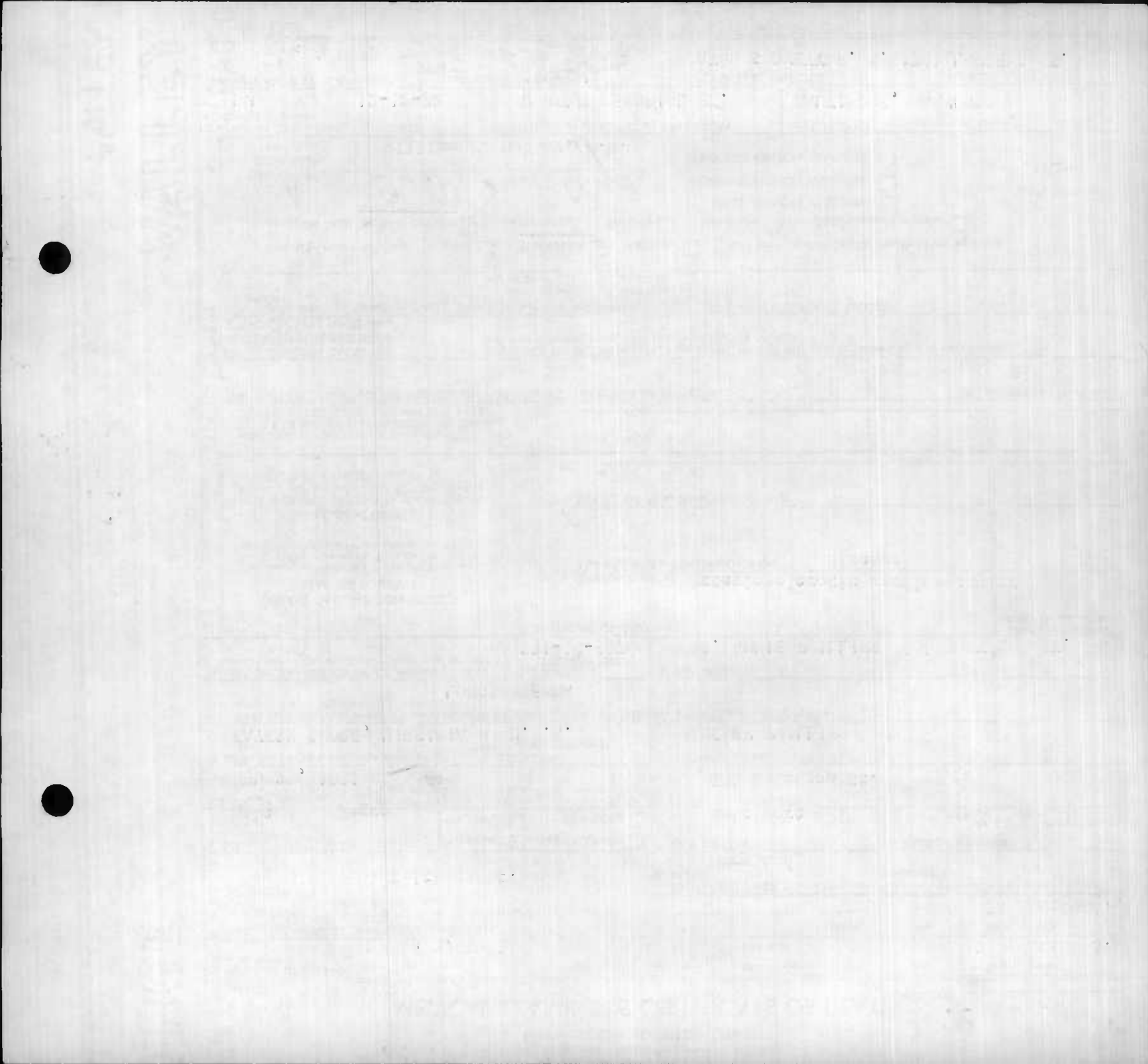
1914-15

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Thomas H. Phillips		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 12 9 72 10:28 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 604 Smithson St.		3. DATE PRONOUNCED DEAD Month Day Year 12 9 72 10:28 A.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH NOV 23, 1911		10. AGE (In years lost birthday) 61	
11. BIRTHPLACE (State or foreign country) EATERN SHORE, VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY LONGSHOREMNA	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO. 231-10-5976	
18. INFORMANT MRS. ANNIE PHILLIPS		ADDRESS 604 SMITHSON ST.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE Atteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: William P. Mulloy, M.D. EXAMINER'S NAME (Type) DATE SIGNED: 12-10-72			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 2-12-72	
24C. NAME OF CEMETERY or CREMATORY ARBUTUS MEMORIAL PK.		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. DEC 12 1972		25B. NAME OF REGISTRAR Anthony J. Horton	
25C. FUNERAL DIRECTOR MORTON & DYETT F. H.		ADDRESS 1701 LAURENS ST.	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. STATE OF MARYLAND - DHE
<div style="display: flex; justify-content: space-between;"> <span>R-200</span> <span>72 11740</span> </div>		<div style="display: flex; justify-content: space-between;"> <span>72 11740</span> </div>
BIRTH NO. <span style="float: right;">1</span> 1. NAME OF DECEASED (Type or Print) <b>SAMUEL RUSK</b>		2. DATE AND HOUR OF DEATH <b>12-7-72 12:50 P.M.</b>
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Lutheran Hospital of Maryland</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1506</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1808 Poplar Grove St. 21216</b>
5. SEX <b>M</b> 6. RACE <b>N N</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-22-05</b> 9. AGE (In years last birthday) <b>67</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY <b>DOORMAN</b>	11. BIRTHPLACE (State or foreign country) <b>ATLANTIC CITY, N, J,</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>WILLIAM H. RUSK</b>		14. MOTHER'S MAIDEN NAME <b>MINTA CHASE</b>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>	16. SOCIAL SECURITY NO. <b>218-05-4530</b>	17. INFORMANT <b>WILLIAM RUSK</b> ADDRESS <b>1808 poplar grove st.</b>
18. <b>410.9 I</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Coronary Thrombosis</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Arteriosclerotic Cardiovascular disease</b>		
19A. DATE OF OPERATION <b>22</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>	20A. AUTOPSY? (Yes or No) <b>Yes</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>12-5-1972</b> to <b>12-7-1972</b> that (I) (we) last saw the deceased alive on <b>12-7-1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		
23A. SIGNATURE <b>[Signature]</b>		23B. DATE SIGNED
23C. PHYSICIAN'S NAME (Type) <b>M. A. ANWAR M.D.</b>		23D. ADDRESS <b>Lutheran Hosp. of Maryland</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>12-12-72</b>	24C. NAME OF CEMETERY OR CREMATORY <b>MOUNT CALVARY CEMETERY</b> 24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 12 1972</b>		25B. NAME OF REGISTRAR <b>[Signature]</b> 25C. FUNERAL DIRECTOR <b>MORTON &amp; DYETT F. H</b> ADDRESS <b>1701 LAU RENS STREET</b>



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-520 72 11711		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 11711	
BIRTH NO.		CERTIFICATE OF DEATH		STATE OF MARYLAND	
1. NAME OF DECEASED (Type or Print) <u>James Sims (Simms)</u>		2. DATE AND HOUR OF DEATH <u>12-7-72</u> <u>9.15 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Bon Secours Hospital</u> <u>34</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <u>Maryland</u> B. COUNTY <u>2001</u>	
		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>1807 W Mulberry St.</u>			
5. SEX <u>M</u>	6. RACE <u>Black</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-4-98</u>	9. AGE (in years last birthday) <u>74</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>					
13. FATHER'S NAME <u>Dose Sims</u>		14. MOTHER'S MAIDEN NAME <u>Ida Rambel</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, <input checked="" type="checkbox"/> No, <input type="checkbox"/> Unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>214-24-9957</u>		17. INFORMANT ADDRESS	
18. <u>481X1</u>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>GRAM NEGATIVE SEPTIC SHOCK</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2-3 days</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Bilateral lobar Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>5 days after admission</u>	
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> - Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12/3/72</u> to <u>12/7/72</u> that (I) (we) last saw the deceased alive on <u>12/7/72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Chohan</u>		M.D. DEGREE <u>CHAHAN</u>		23B. DATE SIGNED <u>12/7/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>CHAHAN</u>		23D. ADDRESS <u>BON SECOURS HOSP.</u> <u>2025 W. FAYETTE ST., BALTIMORE, Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-13-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Beulah Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Mayesville, S. C.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 12 1972</u>		25B. NAME OF REGISTRAR <u>John J. ...</u>		25C. FUNERAL DIRECTOR <u>Morton ...</u>	
25D. ADDRESS <u>1201 Laurens Street</u>					





E-400

72 11742

STATE OF MARYLAND DEPARTMENT  
BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 11742

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>FULTON EWELL</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Lutheran Hospital (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>12 10 1972 9:32p</b> M.	
6. SEX <b>male</b>		7. RACE <b>negro</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>1607</b>	
9. DATE OF BIRTH <b>4-18-17</b>		10. AGE (In years last birthday) <b>55</b>	
11. BIRTHPLACE (State or foreign country) <b>APPROMATTOX, VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>EDWARD EWELL</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STEAMSHIP TRADE</b>	
15. MOTHER'S MAIDEN NAME <b>SUSAN WARNER</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES</b>	
17. SOCIAL SECURITY NO. <b>217-03-1723</b>		18. INFORMANT ADDRESS <b>MRS. JENNIE EWELL 1217 POPLAR GROVE ST.</b>	
19. CAUSE OF DEATH <b>Hypertensive cardiovascular disease</b> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>6</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>NO</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Russell S. Fisher, M.D.</b> DATE SIGNED <b>12-11-72</b> EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12-15-72</b>	
24C. NAME of CEMETERY or CREMATORY <b>CARVER MEMORIAL PARK</b>		24D. LOCATION (City, town, or county) (State) <b>LAUREL, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 12 1972</b>		25B. NAME OF REGISTRAR <b>Adrian W. Houston</b>	
25C. FUNERAL DIRECTOR <b>MARTON &amp; DYETT F. H.</b>		ADDRESS <b>1701 laurens st.</b>	

OFFICE

RECEIVED

1917-18-19

2000

1000

1000

# FUNERAL DIRECTOR: IMPORTANT

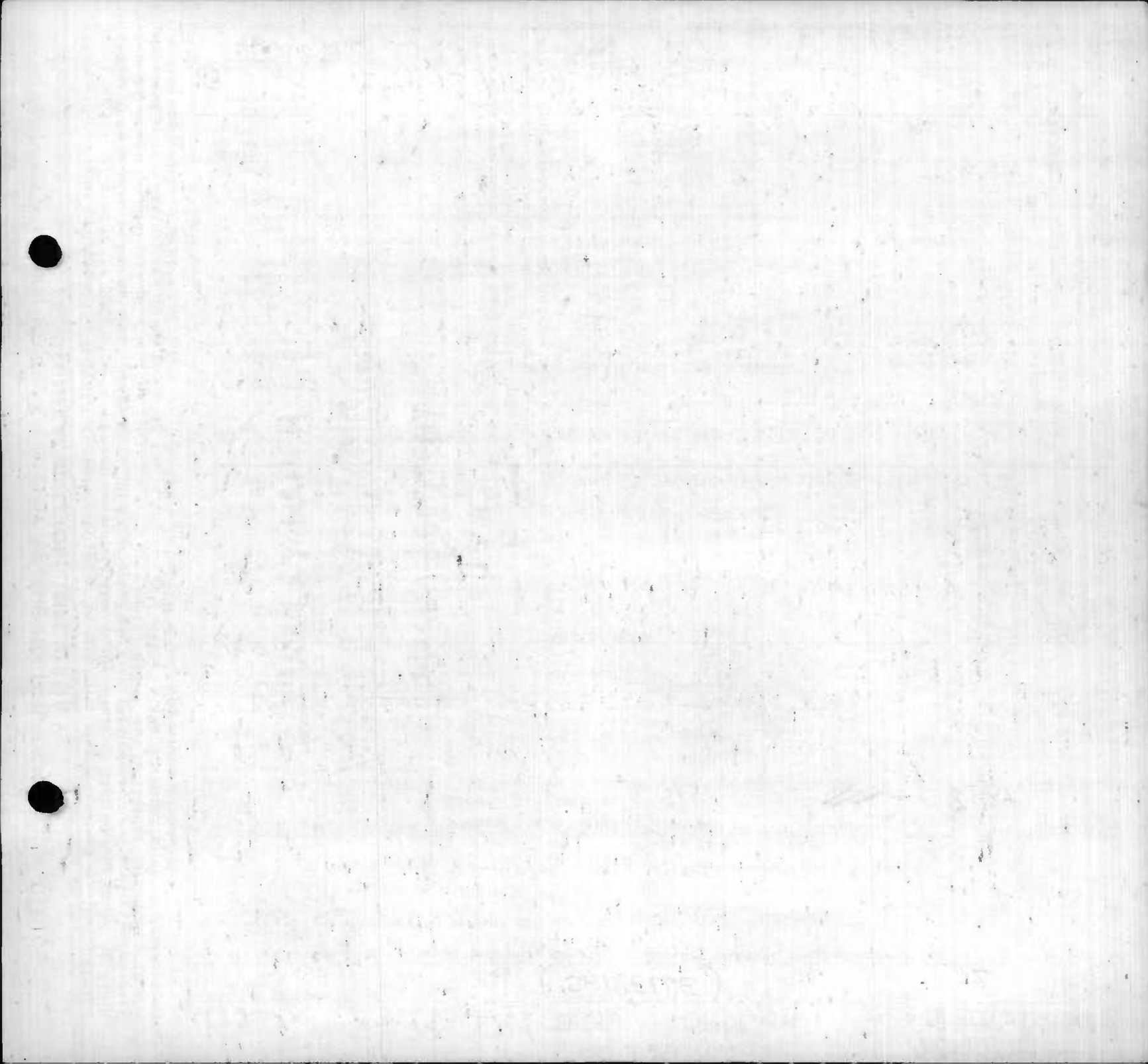
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 11743	
A-425 72 11743				BIRTH NO. 72 11743	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH	
Mack ALLISON				10 45 PM 12-6-72 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY	
Johns Hopkins Hospital 33				Md	
5. SEX m				6. RACE Negro	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 8/28/14	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				9. AGE (In years last birthday) 58	
Cook				11. BIRTHPLACE (State or foreign country) FAYETTEVILLE, N.C.	
13. FATHER'S NAME John Allison				12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				17. INFORMANT ADDRESS	
NO				WIFE 457 WOLF ST.	
16. SOCIAL SECURITY NO. 162-16-2461				14. MOTHER'S MAIDEN NAME SARAH Jenkins Blackman	
18. 431.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Renal FAILURE	
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF: (L) temporal hematoma	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) Stress ulcer, Sepsis	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 12/6 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE B. Stechmiller MD				23B. DATE SIGNED 12/6	
23C. PHYSICIAN'S NAME (Type) Bruce Stechmiller MD				23D. ADDRESS Apt 1006 550 N BROADWAY	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-11-72		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn	
24D. LOCATION (City, town, or county) BALTO, Md.		24E. LOCATION (State) BALTO, Md.			
25A. DATE REC'D BY HEALTH DEPT. DEC 12 1972		25B. NAME OF REGISTRAR Sydney H. [Signature]		25C. FUNERAL DIRECTOR E. O. Wilson	
25D. ADDRESS 1000 BEANTLEY AVE					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 11744	
P-460 72-00245 72 11744				REG. NO. 72 11744	
BIRTH NO.				STATE OF MARYLAND - DEATH	
1. NAME OF DECEASED (Type or Print) <b>Sherri H Paylor (SHIRELLE)</b>			2. DATE AND HOUR OF DEATH <b>December 10, 72</b> <b>4 M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Johns Hopkins Hospital</b> <b>Emergency Room</b>			A. STATE <b>Maryland</b> B. COUNTY <b>908</b>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <b>2108 Homewood Avenue</b>					
5. SEX <b>F</b>	6. RACE <b>B</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/16/72</b>	9. AGE (In years last birthday) <b>8 2/4</b>	10. Under 1 Yr. Months: Days: Hours: Min. <b>8 24</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Baby</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>No</b>		
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Bernard Paylor</b>			14. MOTHER'S MAIDEN NAME <b>Angela Johnson</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>-</b>		
17. INFORMANT <b>parents</b>			ADDRESS		
18. <b>749.2 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH f(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>congenital bilateral cleft lip + palate</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>airway obstruction</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>mucus secretions</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>and complications from congenital defects</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>		
19A. DATE OF OPERATION <b>0 11/72</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Cleft lip</b>		
20A. AUTOPSY? (Yes or No) <b>NO</b>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Patient died at home</b>		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <b>October 1972</b> to <b>December 1972</b> , that (I) (we) last saw the deceased alive on <b>November 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <b>(did)</b> (did not) view the body after death.					
23A. SIGNATURE <b>Mary Beale Berakha MD</b>			23B. DATE SIGNED <b>12/10/72</b>		
23C. PHYSICIAN'S NAME (Type) <b>Mary Beale Berakha MD</b>			23D. ADDRESS <b>550 N. Broadway, Baltimore, Md.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			24B. DATE <b>12-13-72</b>		
24C. NAME OF CEMETERY OR CREMATORY <b>MT. Auburn Cem.</b>			24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>		
25A. DATE RECEIVED BY HEALTH DEPT. <b>DEC 12 1972</b>			25B. NAME OF REGISTRAR <b>Sherri H Paylor</b>		
25C. FUNERAL DIRECTOR <b>Chas. D. Wilson</b>			ADDRESS <b>1000 Brantley Ave.</b>		





7-630

72 11745

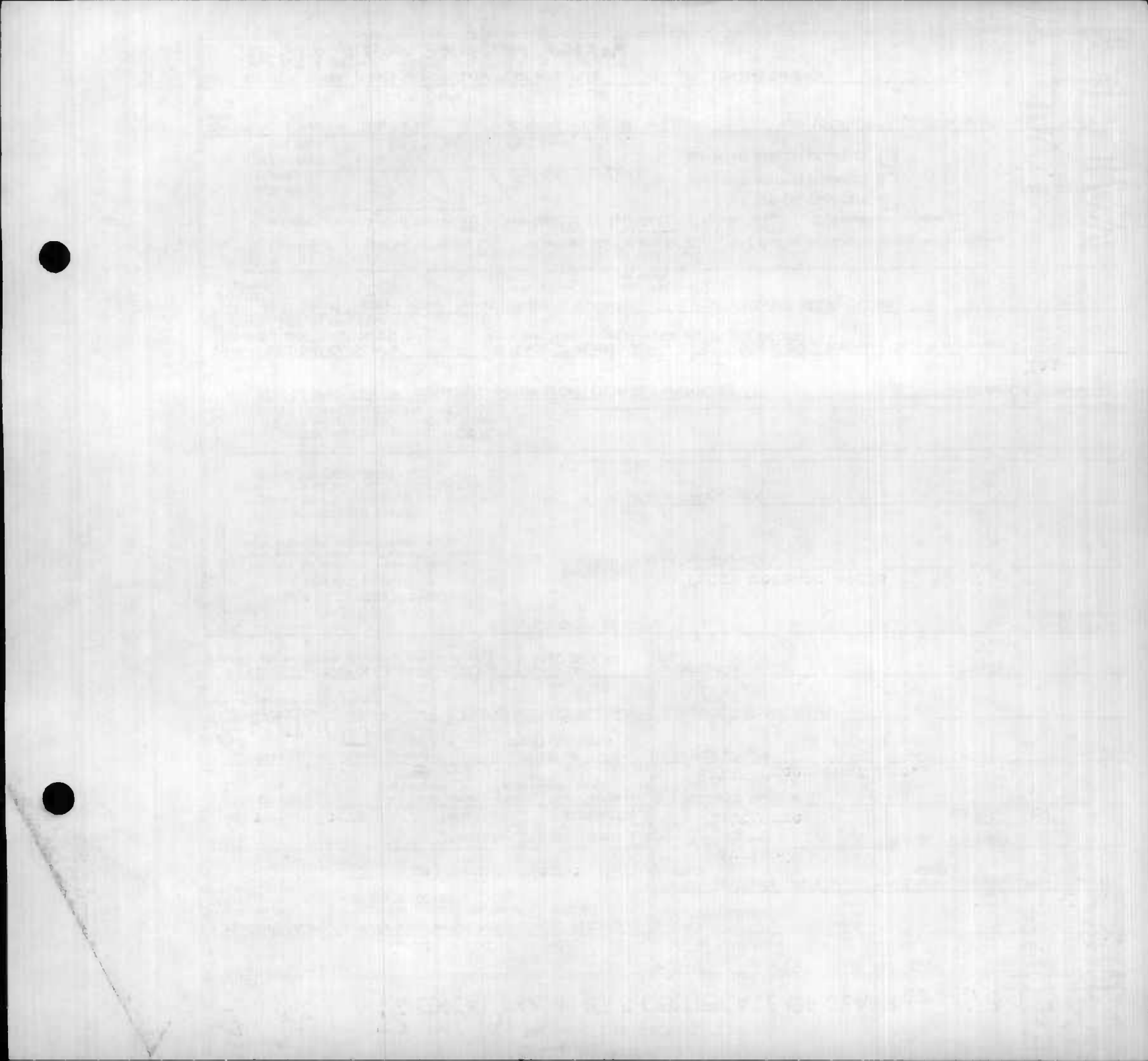
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 11745

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Joseph Ford H.		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 12 9 72 1:43 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1315 Greenmount Avenue		3. DATE PRONOUNCED DEAD Month Day Year 12 9 72 1:43 A. M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission) A. STATE Maryland B. COUNTY 909	
9. DATE OF BIRTH Mar. 9, 1921		10. AGE (in years lost birthday) 51	
11. BIRTHPLACE (State or foreign country) RICHMOND N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Ford		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
15. MOTHER'S MAIDEN NAME FANNIE SUTTON		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, never unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT Thelma Allen	
19. 571.8 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Fatty metamorphosis of liver (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 7		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE William P. Mulloy, M.D. EXAMINER'S NAME (Type) DATE SIGNED 12-9-72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-13-72	
24C. NAME OF CEMETERY or CREMATORY Carver Mem. Park		24D. LOCATION (City, town, or county) (State) md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 12 1972		25B. NAME OF REGISTRAR Anthony [Signature]	
25C. FUNERAL DIRECTOR Chapman G. Wilson		ADDRESS 1000 Brantley Ave.	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 11746	
CERTIFICATE OF DEATH				STATE OF MARYLAND-DEME	
BIRTH NO. M-530 72 11746		2. DATE AND HOUR OF DEATH 12/8/72 303 P.M.			
1. NAME OF DECEASED (Type or Print) Abe Mont		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 704			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) THE JOHNS HOPKINS HOSPITAL 33		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 944 DURHAM ST.					
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWER <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-20-09	9. AGE (in years last birthday) 64	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Disability		10B. KIND OF BUSINESS OR INDUSTRY Steel Worker		11. BIRTHPLACE (State or foreign country) VA.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME ABE MONT		14. MOTHER'S MAIDEN NAME Mary			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-09-1209		17. INFORMANT Mary Trusty 1116 Abbott Ct.	
18. 573.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pulmonary Embolus (B) Hepatic Insufficiency (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/77 19 72 to 12/8 19 72, that (I) (we) last saw the deceased alive on 12/8 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert Friedman		23B. DATE SIGNED 12/8/72			
23C. PHYSICIAN'S NAME (Type) ROBERT FRIEDMAN		23D. ADDRESS THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-14-72		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.	
24D. LOCATION Balto.		24E. mod.			
25A. DATE REC'D BY HEALTH DEPT. DEC 12 1972		25B. NAME OF REGISTRAR Sidney J. Wilson		25C. FUNERAL DIRECTOR E. J. Wilson 1000 Broadway Ave.	

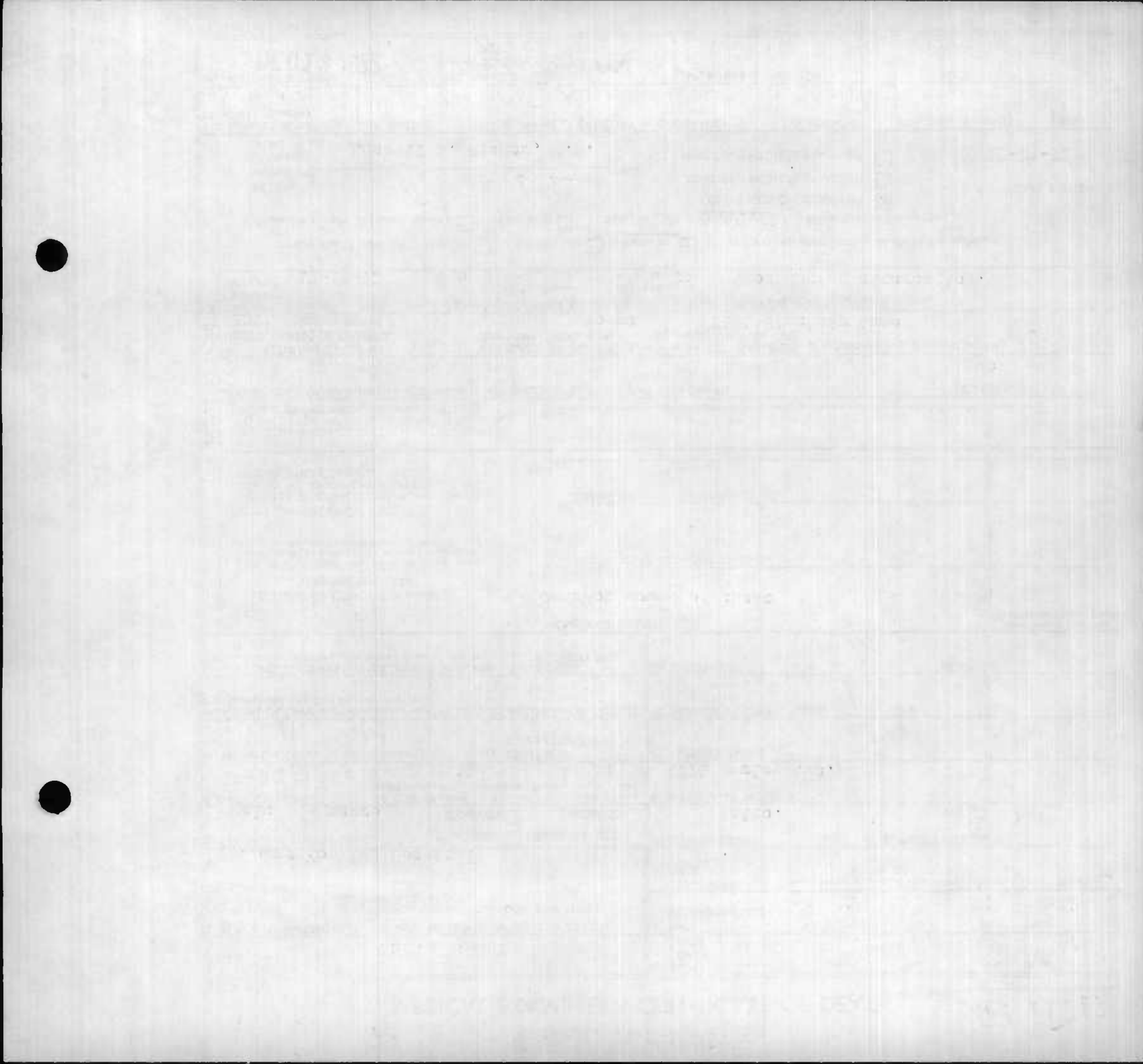
**I** • [EDIFY]

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>DONNIE GLADNEY</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> <b>Dec. 10<sup>th</sup> 1972</b> <b>8 P.</b> <sup>13</sup> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Johns Hopkins Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>12 10 1972 8:13p</b> M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>803</b>			
6. SEX <b>male</b>	7. RACE <b>negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN <b>Balto.</b>
9. DATE OF BIRTH <b>12-21-1956</b>	10. AGE (In years last birthday) <b>15</b> If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.	E. STREET AND NUMBER <b>1771 Daxley Ave.</b>	
11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	13. FATHER'S NAME <b>John Gladney</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		15. MOTHER'S MAIDEN NAME <b>Mamie Sanders</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>—</b>	
18. INFORMANT <b>Mamie Sanders</b>		ADDRESS <b>Same</b>	
19. <b>E965X</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Gunshot wound of chest</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>house</b>	
22D. TIME (Month) (Day) (Year) (Hour) (Approx.) <b>12-10-72 8 p m.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>2101 Sinclair Lane</b>		22F. HOW DID INJURY OCCUR? <b>Shot during altercation.</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Russell S. Fisher, M.D.</b> DATE SIGNED <b>12-11-72</b> EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>12-15-72</b>	24C. NAME of CEMETERY or CREMATORY <b>MT. Auburn Cem.</b>	24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 12 1972</b>		25B. NAME OF REGISTRAR <b>John P. Wilson</b>	
25C. FUNERAL DIRECTOR <b>Chas. Q. Wilson</b>		ADDRESS <b>1000 Brantley Ave. Balt. Md.</b>	



A-450

72

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 11748

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>John Allen</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year <b>12 9 72</b>		Hour <b>4:03 P.</b>
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>33 Johns Hopkins Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>12 9 72</b>		Hour <b>4:03 P.</b>
6. SEX <b>Male</b>		7. RACE <b>Negro</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. DATE OF BIRTH <b>Jan. 18, 1919</b>		10. AGE (In years lost birthday) <b>53</b>		11. BIRTHPLACE (State or foreign country) <b>VA.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Willie Allen</b>		14. MOTHER'S MAIDEN NAME <b>Nannie Randolph</b>
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		16. KIND OF BUSINESS OR INDUSTRY <b>None</b>		17. SOCIAL SECURITY NO. <b>217-26-6601</b>
18. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WWII</b>		19. INFORMANT <b>Helen Harris</b>		20. ADDRESS <b>Same</b>

19. CAUSE OF DEATH <b>412.41</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C)

20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>No</b>
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?

23. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

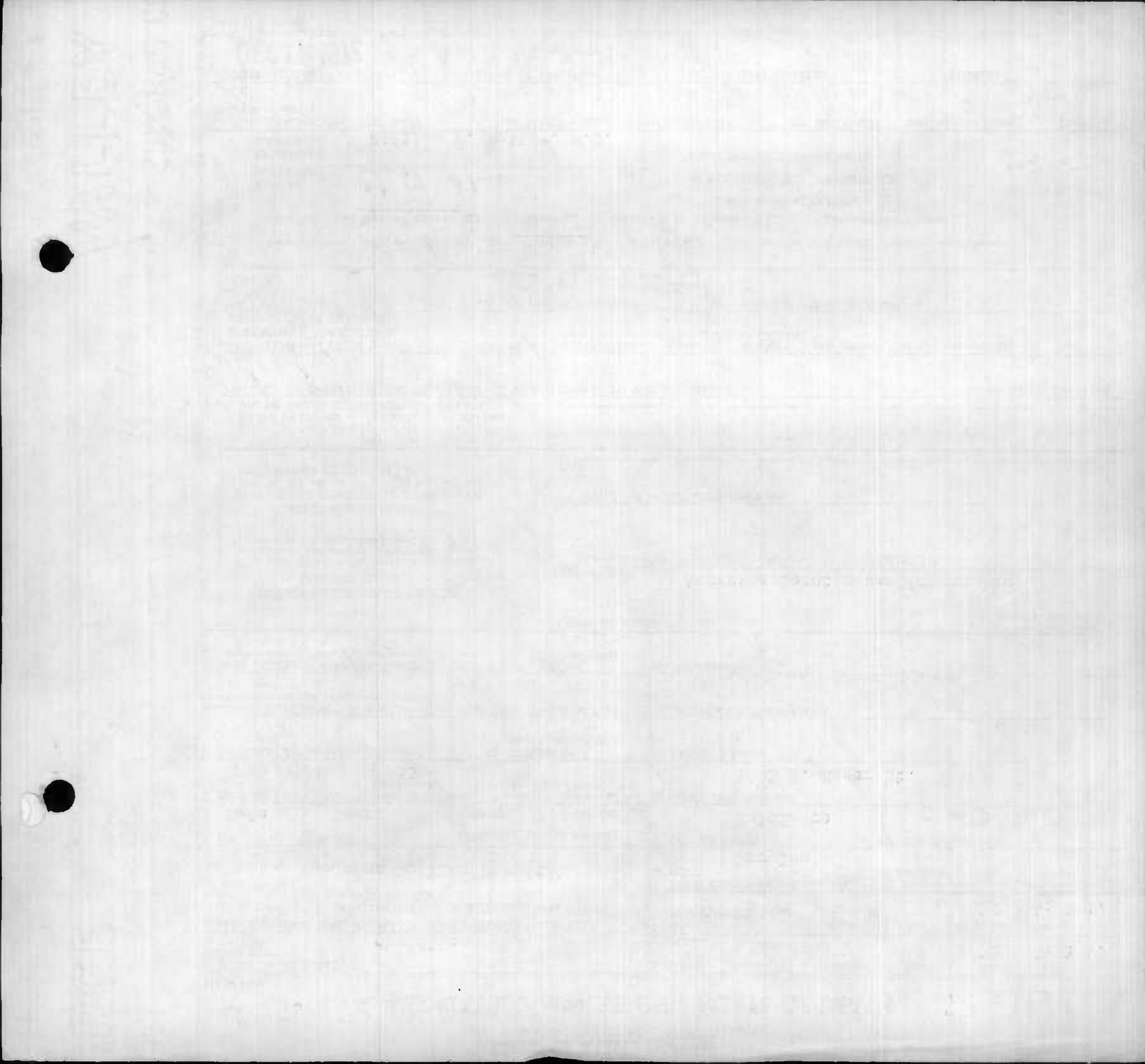
ACTUAL SIGNATURE **W P Mulloy** M.D. CHIEF MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type) **William P. Mulloy, M.D.** ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED **12-10-72**

24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>12-14-72</b>	24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Mem. Park</b>	24D. LOCATION (City, town, or county) (State) <b>Arbutus, Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 12 1972</b>	25B. NAME OF REGISTRAR <b>Audrey Whitton</b>	25C. FUNERAL DIRECTOR <b>Edmund O. Wilson</b>	ADDRESS <b>1000 Branley Ave Balto. Md</b>





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-635		72 11749		BALTIMORE CITY HEALTH DEPARTMENT		72 11749	
BIRTH NO.		CERTIFICATE OF DEATH		STATE OF MARYLAND-DEPT.		REG. NO.	
1. NAME OF DECEASED (Type or Print)		GORDON, HUGO		2. DATE AND HOUR OF DEATH 12/6/72		11:20 AM.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY		MARYLAND		808	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN		D. INSIDE CITY LIMITS?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
THE JOHNS HOPKINS HOSPITAL 33		BALTIMORE		E. STREET AND NUMBER		1030 N. CASTEE ST.	
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-8-13	9. AGE (in years last birthday) 59	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Curer		S. & N. Meat Plant		Orangeburg, S. C.		U. S. A.	
13. FATHER'S NAME JAMES HUGO GORDON.		14. MOTHER'S MAIDEN NAME DELLA LOCKETT					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 242-05-9688		17. INFORMANT		ADDRESS	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Respiratory arrest (B) Aknetic nute Pneumonia DUE TO, OR AS, A CONSEQUENCE OF: Sepsis (C) Renal failure		several minutes			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Renal failure					
19A. DATE OF OPERATION 10/17/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Scrotal gangrene		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 19 to 12-6-1972 that (I) (we) last saw the deceased alive on 12-6-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Cyrus Oundzav M.D.		23B. DATE SIGNED 12/6/72			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS Johns Hopkins Hospital					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-16-72		24C. NAME OF CEMETERY OR CREMATORY Peter Bowman Cem.		24D. LOCATION (City, town, or county) (State) Orangeburg S. C.	
25A. DATE REC'D BY HEALTH DEPT. DEC 12 1972		25B. NAME OF REGISTRAR Sidney Whitton		25C. FUNERAL DIRECTOR B. H. A. Felt		ADDRESS 1000 Broadway Ave. Baltimore	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 72 11750 CERTIFICATE OF DEATH				REG. NO. 72 11750 STATE OF MARYLAND-DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Davis Elmore B.</i>		2. DATE AND HOUR OF DEATH <i>12/10/72 3:30 A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <i>Lutheran Hospital</i> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>1607</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>3313 Poplar Street</i> <i>Hilton N.H.</i>		
5. SEX <i>M</i>	6. RACE <i>N</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-13-06</i>	9. AGE (In years last birthday) <i>66</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>South Carolina</i>	
13. FATHER'S NAME <i>Benjamin Davis</i>			14. MOTHER'S MAIDEN NAME <i>Rosena Kennedy</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>N</i>		16. SOCIAL SECURITY NO. <i>239-10-1759-A</i>		17. INFORMANT <i>Chart</i>	
18. <i>250.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <i>II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>uremia</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 mths.</i>
			(B) <i>chronic Renal failure</i> DUE TO, OR AS A CONSEQUENCE OF:		<i>6 mths.</i>
			(C) <i>Diabetes mellitus</i>		
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1 Month ( ) 1 Day ( ) 1 Year ( ) 1 Hour ( )		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>12/6/72</i> to <i>12/10/72</i> that (I) (we) last saw the deceased alive on <i>12/10/72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>S. S. Dongre</i>			23B. DATE SIGNED <i>12/10/72</i>		
23C. PHYSICIAN'S NAME (Type) <i>S. S. DONGRE</i>			23D. ADDRESS <i>730, Ashburton St. Balto. Md. 21216</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Dec. 13, 72</i>		24C. NAME OF CEMETERY or CREMATORY <i>Arbutus Mem. Park</i>	
		24D. LOCATION <i>Baltimore, Md.</i>		24E. CITY, town, or county (State)	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 12 1972</i>		25B. NAME OF REGISTRAR <i>Sidney [Signature]</i>		25C. FUNERAL DIRECTOR <i>Kenneth Law</i>	
				ADDRESS <i>4611 Park Heights Ave.</i>	

1/28/72

3059 Brighton st.

48-26-93 djr

5-163

72 11751

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO.

72 11751

STATE OF MARYLAND-DHMH

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

WILLIAM SEYFFERTH

(WILLIAM F. J. SEYFFERTH)

2. DATE AND HOUR OF DEATH

DECEMBER 9, 1972

3:27P.

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Baltimore City Hospitals

4940 Eastern Avenue

Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)

A. STATE

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

6203 Eastern Avenue 21224

5. SEX

Male

6. RACE

Caucasian

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

June 17, 1925

9. AGE (In years last birthday)

47

If Under 1 Yr. Months: Days:

If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Crane Operator

10B. KIND OF BUSINESS OR INDUSTRY

Beth. Steel Co.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Frank Seyfferth

14. MOTHER'S MAIDEN NAME

Margaret Beddo

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

Yes

W.W.II

16. SOCIAL SECURITY NO.

217-12-7851

17. INFORMANT

BCH: RECORDS

4940 Eastern Avenue ADDRESS

Baltimore, Maryland 21224

18. 571.01

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B) cirrhosis

DUE TO, OR AS A CONSEQUENCE OF:

(C) chronic alcoholism

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

5d

unknown

24y

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

12

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/6 to 12/9 1972

that (I) (we) last saw the deceased alive on 12/9/72 19 and that in (my) (our) opinion death occurred on the date

and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Herbert G. Markley, M.D.

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

12/9/72

23C. PHYSICIAN'S NAME (Type)

Herbert G. Markley, M.D.

23D. ADDRESS

Baltimore City Hospitals  
4940 Eastern Avenue Baltimore, Maryland 21224

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

12-13-72

24C. NAME of CEMETERY or CREMATORY

St. Stanislaus Cemetery

24D. LOCATION

(City, town, or county)

(State)

6515 Boston Ave., Balto., Md.

25A. DATE REC'D BY HEALTH DEPT

DEC 12 1972

25B. NAME OF REGISTRAR

Audrey H. Korman

25C. FUNERAL DIRECTOR

Charles S. Zeiler

6224 Eastern Ave.

Balto., 21224, Md.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1000

1000

1000

1000

1000

1000

1000

1000

1000

47-09-50 sub 1

BALTIMORE CITY HEALTH DEPARTMENT

72 11752

## CERTIFICATE OF DEATH

REG. NO.

72 11752

STATE OF MARYLAND-DEWE

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Scheben, Carl, R., SR.

2. DATE AND HOUR OF DEATH

12-10-1972

4.05

P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)31 Baltimore City Hospitals  
4940 Eastern Avenue  
Baltimore, Md. 212244. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

415 S. Lehigh Street 21224

5. SEX

Male

6. RACE

Caucasian

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

Nov. 12, 1885

9. AGE (In years  
last birthday)

87

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

Machinist

11. BIRTHPLACE (State or foreign country)

Germany

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Carl Scheben

14. MOTHER'S MAIDEN NAME

Unknown

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

214-03-4397

17. INFORMANT

Records: BCH-4940 Eastern Ave.

ADDRESS

21224

18. 486X I

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, osteoarthritis, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:

Pneumonia

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

3 days

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

ASCVD

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11-15-72 to 12/10-72,  
that (I) (we) last saw the deceased alive on 12-4-10-72 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Matthew N. Fine MD

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

12/10/72

23C. PHYSICIAN'S  
NAME (Type)

Matthew N. Fine MD

23D. ADDRESS

Baltimore City Hospitals 21224

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

12-14-72

24C. NAME OF CEMETERY OR CREMATORY

Oak Lawn Cemetery

24D. LOCATION

(City, town, or county)

(State)

7225 Eastern Blvd., Balto., Md

25A. DATE REC'D BY HEALTH DEPT.

DEC 12 1972

25B. NAME OF REGISTRAR

Andrew H. Hooton

25C. FUNERAL DIRECTOR

901 S. Conkling St.  
Balto., 21224, Md.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

72 11753

## CERTIFICATE OF DEATH

REG. NO.

72 11753

STATE OF MARYLAND-DEM

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

CATHERINE E. WEINEL

2. DATE AND HOUR OF DEATH

December 10, 1972 4:45 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Baltimore City Hospitals

4940 Eastern Avenue

Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE B. COUNTY

Maryland 101

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

3116 Dillon Street 21224

5. SEX

Female

6. RACE

Caucasian

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

July 26, 1889

9. AGE (in years  
last birthday)

83

If Under 1 Yr.

Months Days

If Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

House Work

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Michael Winkelman

14. MOTHER'S MAIDEN NAME

Elizabeth Meier

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

215-12-7034

17. INFORMANT

4940 Eastern Avenue ADDRESS

BCH: RECORDS Baltimore, Maryland 21224

18. 410.91 + 250.9

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Cardiac arrest

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(B) Congestive heart failure

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

diabetes, myocardial infarction

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Dec 3 19 72 to Dec 10 19 72  
that (I) (we) last saw the deceased alive on Dec 10 19 72 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Marilee Cole, M. D.

DEGREE

Attending  
Phys. ☒Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

December 14, 1972

23C. PHYSICIAN'S  
NAME (Type)

Marilee Cole, M. D.

DEGREE

23D. ADDRESS Baltimore City Hospitals

4940 Eastern Avenue Baltimore, Maryland 21224

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

12-14-72

24C. NAME of CEMETERY or CREMATORY

Bohemian National Cem.

24D. LOCATION

Horner's Lane, Balto., Md.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

Lahar... Giler

901 S. Conkling St.  
Balto., 21224, Md.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. Introduction

2. Objectives

3. Methodology

4. Results

5. Conclusion

6. References

7. Appendix

8. Bibliography

9. Glossary

10. Index

11. Acknowledgements

12. Disclaimer

13. Contact Information

14. Copyright

15. Privacy Policy

16. Terms of Service

17. About Us

18. FAQ

19. News

20. Press

21. Careers

22. Partners

23. Sponsors

24. Media

25. Events

26. Awards

27. Press Releases

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 11754	
72 11754				STATE OF MARYLAND-DHMH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Geraldine Ebbert</b>		2. DATE AND HOUR OF DEATH <b>29 Dec. 72 10 58 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2744</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>HOSP. BALTO. INC</b>		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>FEMALE</b>		6. RACE <b>Cauc.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>12-14-19</b>		9. AGE (In years last birthday) <b>52</b>		10. If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WORK</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>KEYSER, W. VA.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>WALTER COX</b>		14. MOTHER'S MAIDEN NAME <b>CLARA GROVE</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>215-16-4806</b>		17. INFORMANT <b>ROBERT J. EBBERT</b> ADDRESS <b>6000 ALTA AVE. BALTO., 21206, MD.</b>	
18. <b>174X I</b> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CVA</b>				<b>12 hrs.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(B) Metastatic Carcinoma of Breast</b>				<b>2 yrs.</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>11-28-72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Bilat. Adrenalectomy</b>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>(H)</del> (this hospital) attended the deceased from <b>11/28</b> 19 <b>72</b> to <b>12/9</b> 19 <b>72</b> that <del>(H)</del> (we) lost saw the deceased alive on <b>12/9</b> 19 <b>72</b> and that in <del>(my)</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>(H)</del> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Michael Schultz MD</b> DEGREE				23B. DATE SIGNED <b>12/9/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>SCHULTZ, MICHAEL MD</b> DEGREE				23D. ADDRESS <b>SINAI HOSP. INC.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12-13-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>OAK LAWN CEM.</b>	
24D. LOCATION (City, town, or county) (State) <b>7225 EASTERN BLVD. BA. CO., MD.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 12 1972</b>			
25B. NAME OF REGISTRAR <b>Ardisy...</b>		25C. FUNERAL DIRECTOR <b>Charles J. Guler</b> ADDRESS <b>901 S. CONKLING ST. BALTO., 21224 MD.</b>			

6 606 15-13-11 GUK TIVU CEW

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/68

*[Faint, illegible handwriting at the top of the page]*

*[Faint, illegible handwriting in the middle section of the page]*

*[Faint, illegible handwriting at the bottom of the page]*



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 11756 CERTIFICATE OF DEATH		REG. NO. 72 11756	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>WILLIAM A. SOMMERVILLE (SOMERVILLE)</u>		2. DATE AND HOUR OF DEATH <u>12-11-72</u>		STATE OF MARYLAND - <u>DEATH</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Lutheran Hospital of Maryland</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1603</u>		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>M</u>				6. RACE <u>N.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>5-10-92</u>		9. AGE in years last birthday <u>80 80</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Not clear</u>		11. BIRTHPLACE (State or foreign country) <u>CLARKSVILLE TN</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13. FATHER'S NAME <u>Sosanna Somerville</u>		14. MOTHER'S MAIDEN NAME <u>Agnes Royston</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hannibal Fletcher 1614 W. Lafayette St.</u>		18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>ALCOHOLIC CIRRHOSIS + evidence of 3 weeks</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>?</u> <u>3 years</u>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (if this hospital) attended the deceased from <u>12-7-72</u> to <u>12-11-72</u> that (if we) last saw the deceased alive on <u>12-11-72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (if we) (did) (did not) view the body after death.		23A. SIGNATURE <u>William A. Anwar MD</u>	
23B. DATE SIGNED <u>12-11-72</u>		23C. PHYSICIAN'S NAME (Type) <u>M. A. ANWAR MD</u>		23D. ADDRESS <u>Lutheran Hospital of Maryland</u>		24A. BURIAL CREMATION, REMOVAL (Specify)	
24B. DATE <u>12/11/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>ARCTUS MON. PK</u>		24D. LOCATION (City, town, or county) (State) <u>BALTO MD 21227</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 12 1972</u>	
25B. NAME OF REGISTRAR <u>Sidney H. Hinton</u>		25C. FUNERAL DIRECTOR <u>W. N. Hays</u>		25D. ADDRESS <u>135 N. 9th St</u>		VS 150-REV. 1/1/68	

*[Faint, illegible handwriting at the top of the page]*

*[Faint, illegible handwriting in the lower left section]*

*[Faint, illegible handwriting in the lower right section]*

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 11757		72 11757	
CERTIFICATE OF DEATH				STATE OF MARYLAND-DEMET		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>HENRY PRESIDENT</b>				2. DATE AND HOUR OF DEATH <b>12/11 7:35 AM</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>UNIVERSITY OF MARYLAND 38 HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>1606</b>			
				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>913 ELLIOTT DR</b>			
5. SEX <b>M</b>	6. RACE <b>BN</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/14/45</b>		9. AGE (In years last birthday) <b>27</b>	10. If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER SANITATION DEPT</b>				11. BIRTHPLACE (State or foreign country) <b>BALTO MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>WILLIE PRESIDENT</b>				14. MOTHER'S MAIDEN NAME <b>ANNA ERVIN</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>ANNA F. PRESIDENT 913 ELLIOTT DR</b>	
18. <b>59321</b> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>PULMONARY EDEMA</b>				<b>14 hrs</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				<b>CARDIAC ARREST</b>			
				<b>14 hrs</b>			
				<b>MONTHS</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>ANEMIA</b>							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>12/10</b> 19 <b>72</b> to <b>12/11</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>12/11</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Thomas E. Murphy Jr MD</b>				23B. DATE SIGNED <b>12/11/72</b>		23C. PHYSICIAN'S NAME (Type) <b>THOMAS E. MURPHY JR MD</b>	
23D. ADDRESS <b>UNIVERSITY HOSPITAL BALT. MD</b>				23E. DATE REC'D BY HEALTH DEPT. <b>DEC 12 1972</b>		23F. NAME OF REGISTRAR <b>Indey Indey</b>	
23G. NAME OF CEMETERY OR CREMATORY <b>NO AUBURN</b>				23H. LOCATION (City, town, or county) (State) <b>BALTO MD</b>		23I. FUNERAL DIRECTOR <b>Phyllis B. Blythe 6386 York Rd</b>	
23J. DATE OF BURIAL OR CREMATION (Specify) <b>12/14/72</b>				23K. NAME OF CEMETERY OR CREMATORY <b>NO AUBURN</b>		23L. LOCATION (City, town, or county) (State) <b>BALTO MD</b>	

913 ELLICOTT DR

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 11758</u>
72 11758				STATE OF <u>MARYLAND</u>
BIRTH NO.		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>ARTHUR, FRANCES</u>		2. DATE AND HOUR OF DEATH <u>Dec. 8, 1972</u> <u>9:05 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>South Balto General Hospital</u> <u>43</u>		A. STATE <u>MD</u> B. COUNTY <u>1901</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <u>1628 W. LEXINGTON ST</u>				
5. SEX <u>F</u>	6. RACE <u>COL</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/6/1892</u>	9. AGE (In years last birthday) <u>80</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Edgemoor Co. N.C.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>Louis Mills</u>		14. MOTHER'S MAIDEN NAME <u>FANNIE</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Louis Mills 1628 W. Lexington St</u>
18. <u>2509 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Bronchopneumonia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Arteriosclerotic Cardiovascular Disease with Diabetes Mellitus. C.H.F.</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <u>C.H.F.</u>		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No.</u>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>Dec. 1</u> 19 <u>72</u> to <u>Dec. 8</u> 19 <u>72</u> , that (I) (we) last saw the deceased alive on <u>Dec. 8</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (Did) (did not) view the body after death.				
23A. SIGNATURE <u>Duck Sung Chun MD</u> DEGREE				23B. DATE SIGNED <u>Dec. 8 '72</u>
23C. PHYSICIAN'S NAME (Type) <u>DUCK SUNG CHUN M.D.</u> DEGREE				23D. ADDRESS <u>South Balto General Hospital</u> <u>3001 S. Monrovia St., Balto. Md. 21230</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/14/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>MA AUBURN</u>
24D. LOCATION (City, town, or county) (State) <u>BALTO MD</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 12 1972</u>		25B. NAME OF REGISTRAR <u>Sidney [unclear]</u>		25C. FUNERAL DIRECTOR <u>Marshall [unclear]</u> ADDRESS <u>3859 [unclear] St</u>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 11759 CERTIFICATE OF DEATH		REG. NO. 72 11759		STATE OF MARYLAND-DHMH	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <u>Center - Mary</u>		2. DATE AND HOUR OF DEATH <u>12-6-72</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>1901</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Bolton Hill Nursing Home</u> <u>1400 John Street</u>				E. STREET AND NUMBER <u>312 N. Bruce Street</u>					
5. SEX <u>F</u>	6. RACE <u>B</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-6-98</u>	9. AGE (In years last birthday) <u>74</u>	10. Under 1 Yr. Months	11. Under 24 Hrs. Days	12. Under 24 Hrs. Hours	13. Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Calvert Co MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>MARY S. Gough</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>317-01-942</u>		17. INFORMANT <u>Administration</u>				
18. <u>4369 I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CUA</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <u>12-4-72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>11-5</u> 19 <u>72</u> to <u>12-6</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>12-4</u> 19 <u>72</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>E. Elsworth Cook MD</u>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>12-7-72</u>			
23C. PHYSICIAN'S NAME (Type) <u>E. Elsworth Cook MD</u>				23D. ADDRESS <u>2431 Maryland Ave Balto 21218 MD</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/9/72</u>		24C. NAME of CEMETERY or CREMATORY <u>MT AUBURN</u>		24D. LOCATION (City, town, or county) (State) <u>BALTO MD</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 12 1972</u>		25B. NAME OF REGISTRAR <u>Sidney [Signature]</u>		25C. FUNERAL DIRECTOR <u>[Signature]</u>		ADDRESS <u>[Signature]</u>			



Handwritten text at the top of the page, possibly a title or header.

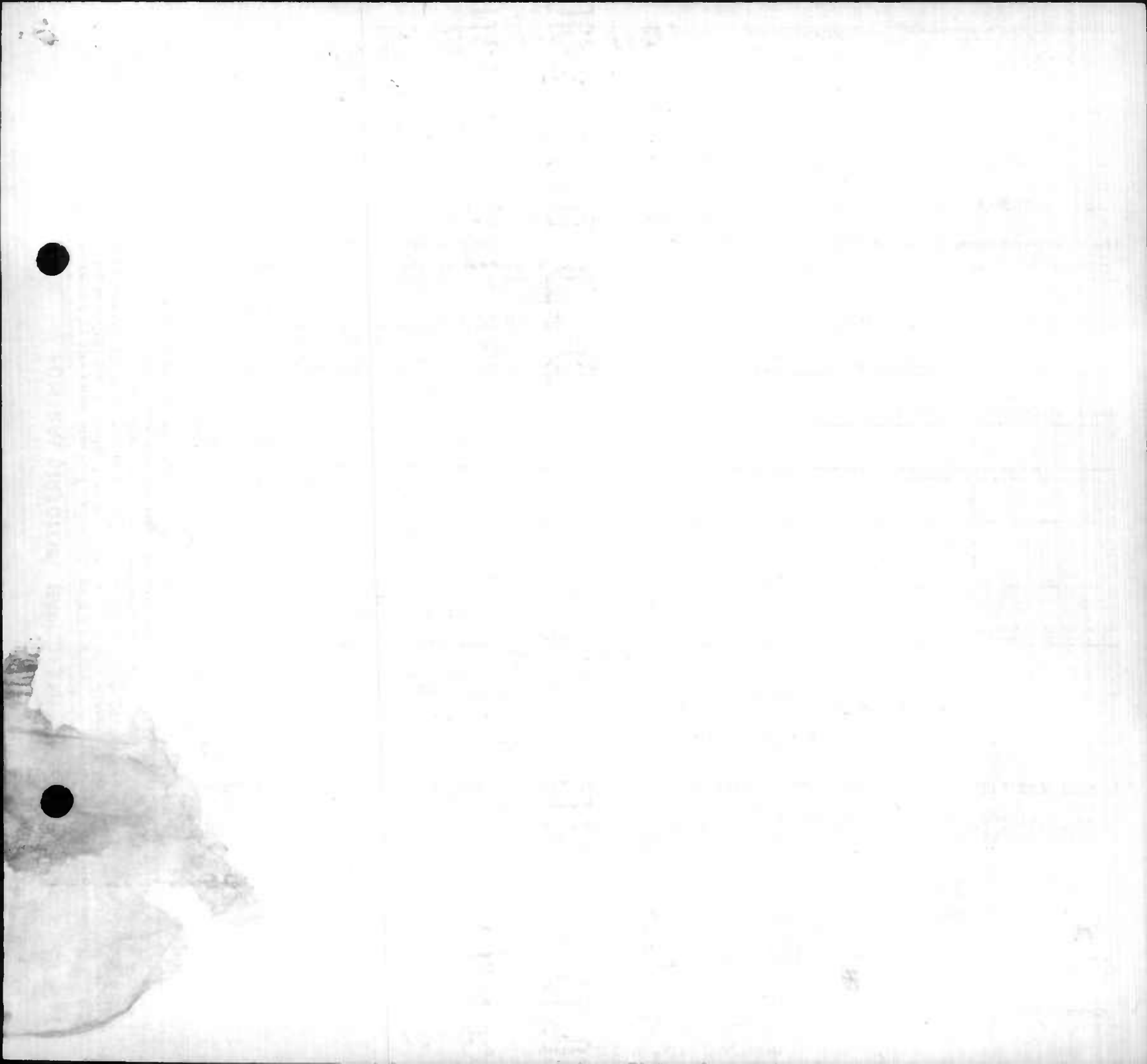
Handwritten text in the upper middle section of the page.

Handwritten text in the lower middle and bottom sections of the page.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

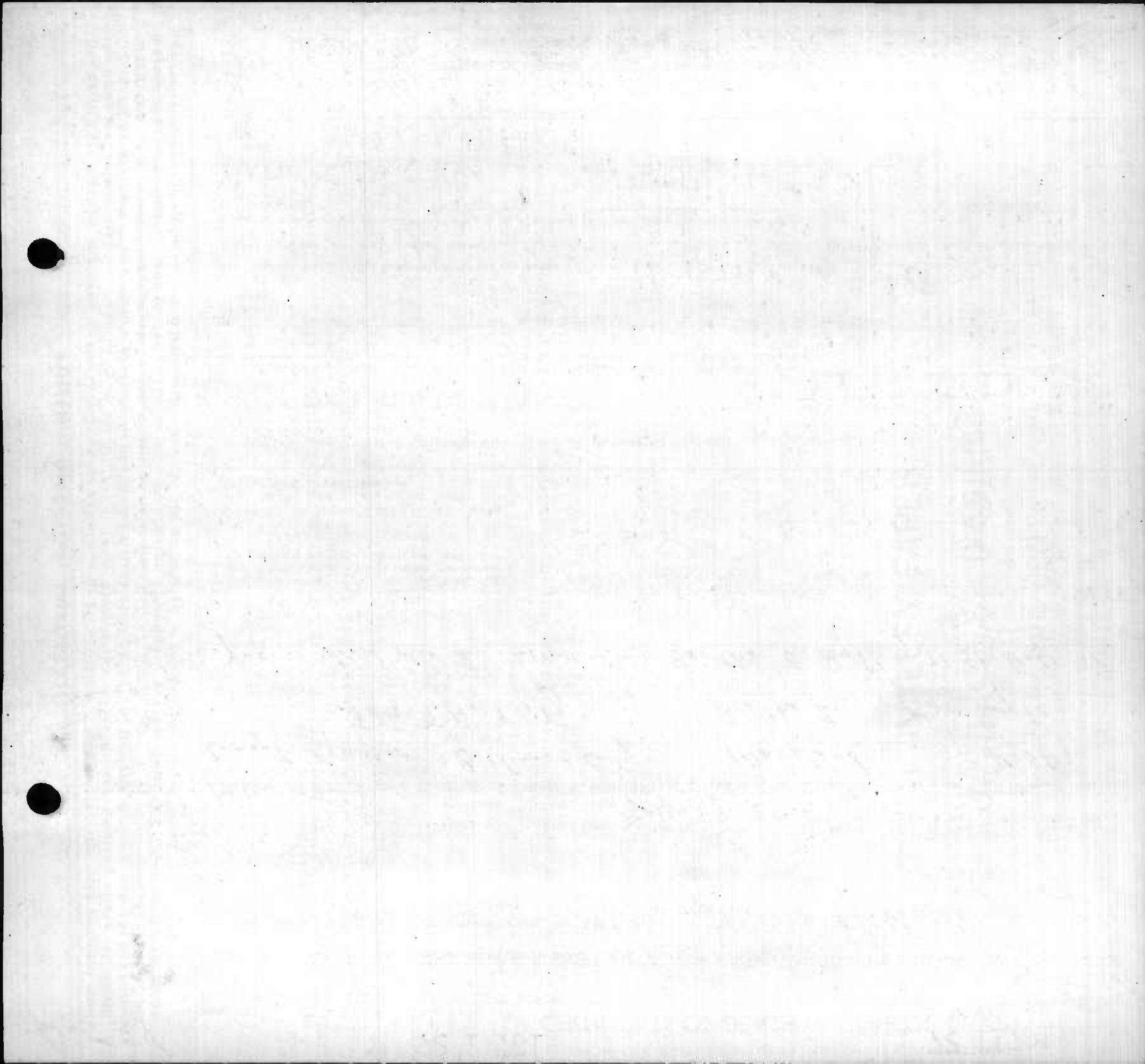
72-11760 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 72-11760 STATE OF <del>Maryland</del>	
BIRTH NO. 534		1. NAME OF DECEASED (Type and Print) EMMA ANNA SINSKY		2. DATE AND HOUR OF DEATH DEC-7-72 3:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2401	
FULL NAME OF HOSPITAL OR INSTITUTION SOUTH BALTIMORE GENERAL HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 1226 HULL STREET					
5. SEX FEM	6. RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-30-01	9. AGE (In years last birthday) 71	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frederick OBERG			14. MOTHER'S MAIDEN NAME LUCILLE BROMO		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO. 220-03-6451		17. INFORMANT RODOLFO TOMASINO, M.D. ADDRESS SOUTH BALT. GEN. HOSP.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DUE TO, OR AS A CONSEQUENCE OF: Cerebrovascular Accident DIABETES MELLITUS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-3-72 to 12-7-72 that (I) (we) last saw the deceased alive on 12-6-72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE R. Tomasino, M.D.				23B. DATE SIGNED Dec-7-72	
23C. PHYSICIAN'S NAME (Type) RODOLFO TOMASINO, M.D.				23D. ADDRESS 3001 S. HANOVER ST., BALT. MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/11/72		24C. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery	
24D. LOCATION Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. DEC 12 1972		25B. NAME OF REGISTRAR Audrey Johnston		25C. FUNERAL DIRECTOR Charles E. Stevens Funeral Home, Inc. 1501 East Fort Avenue	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

72 11761 BALTIMORE CITY HEALTH DEPARTMENT				72 11761	
BIRTH NO.				STATE OF MARYLAND	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Antlitz Thomas		12-8-72 12-00			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			
37 Mercy -		1131 Hull St 2401			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY			
C. CITY OR TOWN		D. INSIDE CITY LIMITS?			
Balt. Md.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER		21230			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
M	W		4-29-27	45	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Cement Finisher		Baltimore City		Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
John T. Antlitz		Bertha E. Harrington			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes World War II		219-10-9344		Bertha E. Antlitz 1131 Hull St.	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		Aorta Mi.			
II ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		A.S.H.D.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C)			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-7-72 to 12-8-72, that (I) (we) last saw the deceased alive on 12-8-72 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
Paul Maki				STAWKIN-MALEK	
23D. ADDRESS		23E. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		12/12/72		Holy Cross Cemetery	
24D. LOCATION (City, town, or county)		24E. LOCATION (State)			
Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
DEC 12 1972		Andrew W. Horton		Charles L. Tavenas Funeral Home, Inc. 1506 E. Fort Avenue	



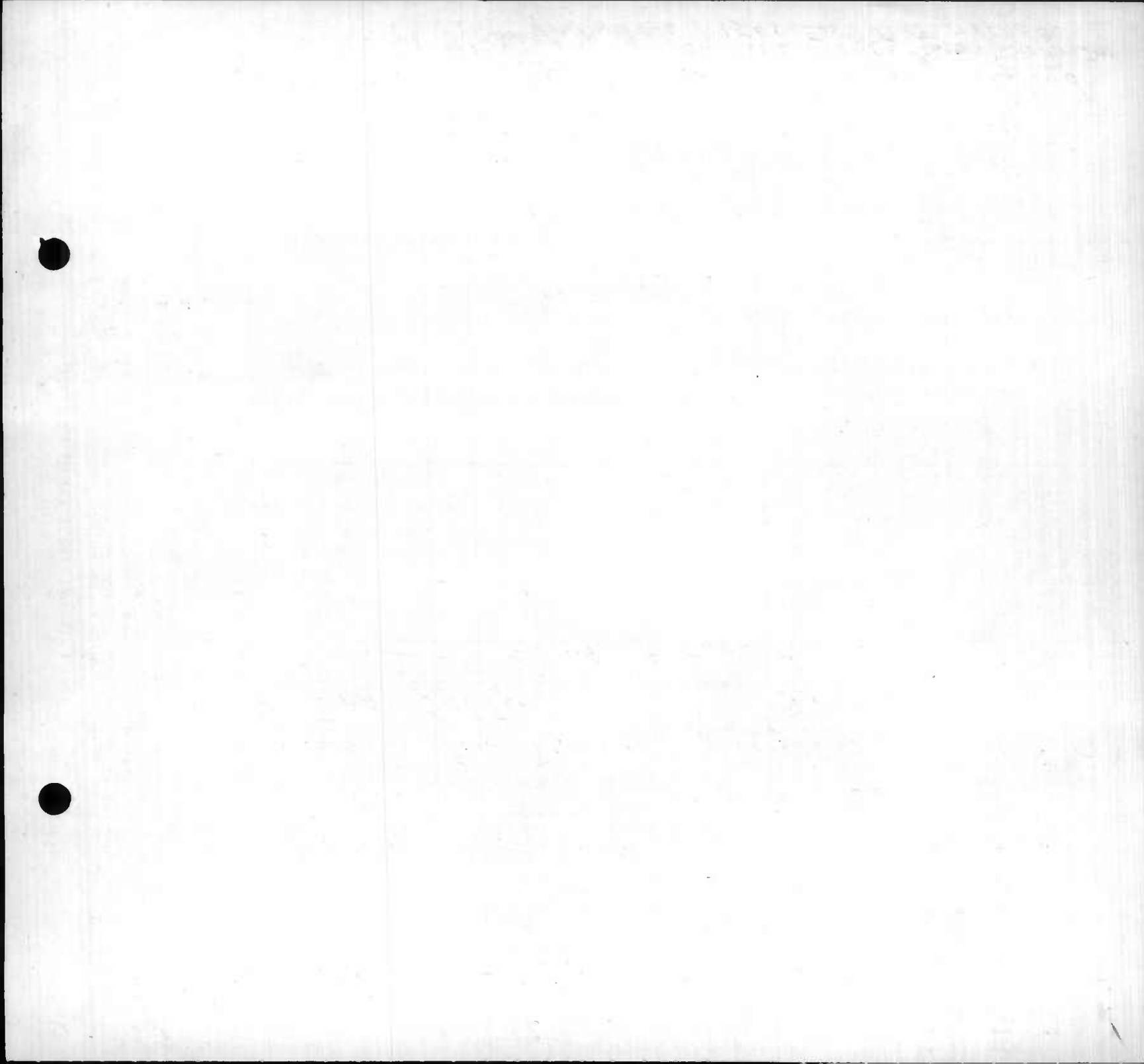
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
72 11762 CERTIFICATE OF DEATH

REG. NO. 72 11762  
STATE OF MARYLAND-DHMH

BIRTH NO. 72 11762		2. DATE AND HOUR OF DEATH 12-3-72 2:30 A.M.	
1. NAME OF DECEASED (Type or Print) MICHAEL A. SUTTON		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 831	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 2205 Kentucky Avenue Baltimore, Maryland 21213		E. STREET AND NUMBER 2205 Kentucky Avenue	
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-9-06 66
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 5 1/2 Yrs. Foreman		11. BIRTHPLACE (State or foreign country) Maryland	
10B. KIND OF BUSINESS OR INDUSTRY Edward J. Fick & Co.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John SUTTON		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-01-9957A	
17. INFORMANT Anna H. SUTTON		ADDRESS 2205 Kentucky Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH I Carcinoma Prostate (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: e Metastases to Brain + spinal cord (B) DUE TO, OR AS A CONSEQUENCE OF: (C) ASCVD - II 3 Ch Bile duct + angiodysplasia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/15/72 to 12/13/72, that (I) (we) lost saw the deceased alive on 12/1/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE [Signature]		23B. DATE SIGNED 12/4/72	
23C. PHYSICIAN'S NAME (Type) DONALD W. MINTZER		23D. ADDRESS 3009 EVERGREEN AVE BALTIMORE 21216	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/6/72	
24C. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		24D. LOCATION Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 12 1972		25B. NAME OF REGISTRAR [Signature]	
25C. FUNERAL DIRECTOR Charles L. Stevens Funeral Home, Inc.		ADDRESS 1501 East Fort Avenue	

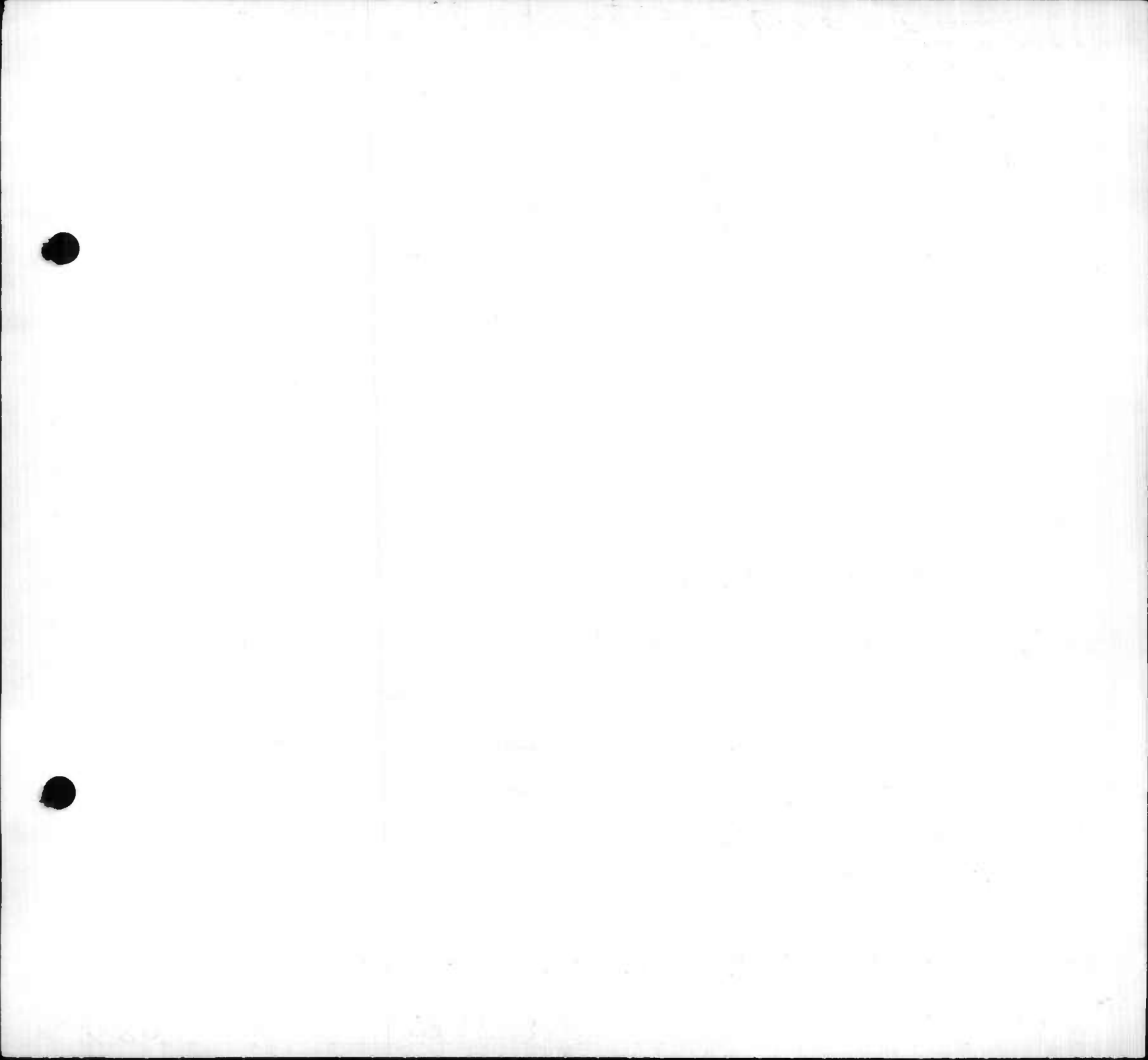




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		72 11763		BALTIMORE CITY HEALTH DEPARTMENT		72 11763		REG. NO.	
1. NAME OF DECEASED (Type or Print)		Andrew Frank Marosz		CERTIFICATE OF DEATH		STATE OF MARYLAND		December 6, 1972 10A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. DATE AND HOUR OF DEATH		6. STATE		7. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION  00336 E. Fort Ave.		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Md.		2401		C. CITY OR TOWN Baltimore	
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 1336 E. Fort Ave.		8. DATE OF BIRTH 11-15-1887		9. AGE (In years last birthday) 85		10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
Longshoreman				Hungary		USA		FRANK Marosz	
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
Unknown		no		215-03-0679		MRS. Mary Koch (daughter) same		5-1158 Columbia St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		19. CAUSE OF DEATH		20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		21. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		22. 5 yrs	
This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.		Antecedent Causes		DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
12-6-72		same		no		no		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED	
no		21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 6-28-1971 to 12-6-1972	
22. I certify that (I) (this hospital) attended the deceased from 6-28-1971 to 12-6-1972		23. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
23. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		24. BURIAL CREMATION, REMOVAL (Specify)	
C. C. Chiu M.D.		12-6-72		C. C. CHIU, M.D.		1 E. Randall Ex. Balto. Md. 21230		Burial	
24. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT.	
Burial		12/9/72		Holy Cross Cemetery		Baltimore, Maryland		DEC 12 1972	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		25D. ADDRESS		25E. ADDRESS	
DEC 12 1972		Dorothy H. Heston		Charles E. Stevens, Funeral Home, Inc.		1501 E. Fort Avenue			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-410		72 11764		BALTIMORE CITY HEALTH DEPARTMENT		72 11764	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) WOLFE, GLENN WESLEY				2. DATE AND HOUR OF DEATH DECEMBER 11, 1972 1:30 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST. AGNES HOSPITAL WILKENS & CATON AVENUES BALTIMORE, MARYLAND 21229				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 716 WOODSDALE ROAD 21228			
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 27 01	9. AGE (In years last birthday) 71	If Under 1 Yr. Months: Days: Hours: Min.	11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SELF EMPLOYED				10B. KIND OF BUSINESS OR INDUSTRY AUTO PARTS INC.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JOHN WESLEY WOLFE				14. MOTHER'S MAIDEN NAME BERTHA FOLLMER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 219109572		17. INFORMANT CATON AVENUES, BALTIMORE, MD. 21229 ST AGNES HOSPITAL RECORDS, WILKENS &			
18. <u>571.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Liver cirrhosis</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Congestive heart failure</u> (C) <u>hepatic coma.</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> At Work		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from <u>NOVEMBER 8, 1972</u> to <u>DECEMBER 11, 1972</u> , that (X) (we) last saw the deceased alive on <u>DECEMBER 11, 1972</u> and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did X) (X) (X) view the body after death.							
23A. SIGNATURE <u>Fereydoun Dehkhareghani</u> DEGREE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12-11-72	
23C. PHYSICIAN'S NAME (Type) FEREYDOUN DEHKHAREGHANI, M.D.				23D. ADDRESS BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS & CATON AVE			
24A. BURIAL CREMATION, REMOVAL (Specify) REM. BURIAL		24B. DATE 12-11-72		24C. NAME OF CEMETERY OR CREMATORY FOLLMER CHURCH CEMETERY		24D. LOCATION (City, town, or county) (State) TURBOT TOWNSHIP NORTHUMBERLAND CO. PA.	
25A. DATE REC'D BY HEALTH DEPT. DEC 12 1972		25B. NAME OF REGISTRAR <u>Anthony Jenkins</u>		25C. FUNERAL DIRECTOR H. W. JENKINS & SONS CO. 4905 YORK ROAD BALTO. MD. 21212			

[illegible]

31210215

**7. 2. 1. NEZREK MODEL**

DECEMBER 1997

2010 2011 2012

NOTE: \*  $p < 0.05$ ; †  $p < 0.01$ ; ‡  $p < 0.001$ .

105011

PIPER: C. GOLD VARNER

DEPARTED 12:11 PM

S-500

72 11765

BALTIMORE CITY HEALTH DEPARTMENT

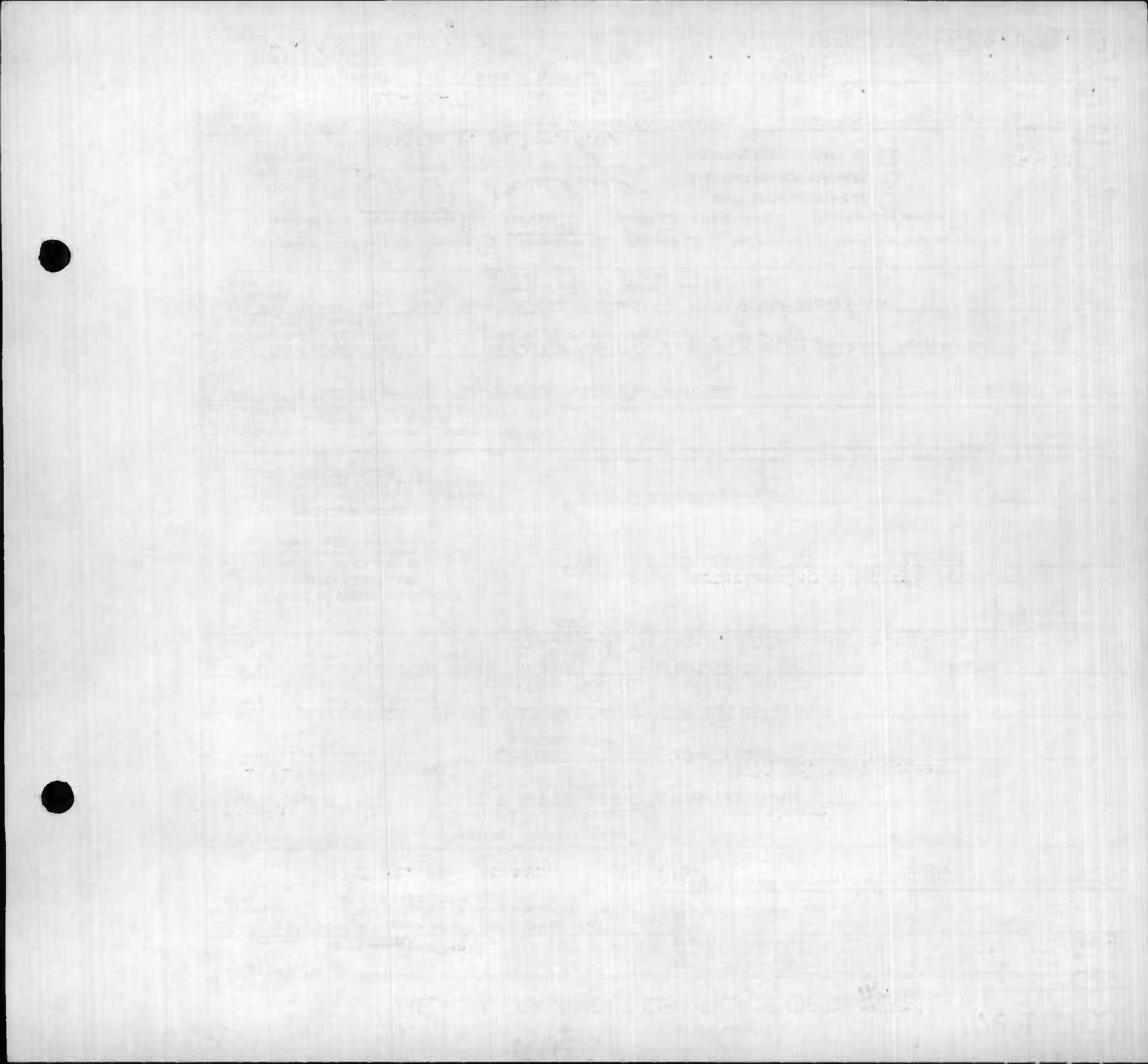
72 11765

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Anna Sheehan</b>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 12 8 72 12:40 P.M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>2713 St. Paul Street</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour 12 8 72 12:40 P.M.			
6. SEX <b>Female</b>				7. RACE <b>White</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>8-25-1883</b>				10. AGE (in years last birthday) <b>89</b>		11. BIRTHPLACE (State or foreign country) <b>Ireland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>Thomas Devine</b>		14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1203</b>	
15. MOTHER'S MAIDEN NAME <b>Mary Kenny</b>				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, near unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>215-40-8408</b>	
18. INFORMANT <b>Mrs. Eileen McEntee</b>				19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C)</b>		20. DATE OF OPERATION <b>12-9-72</b>	
21. AUTOPSY? (Yes or No) <b>No</b>				22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		23. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Balto.</b>	
24. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				25. DATE <b>12-12-72</b>		26. NAME OF CEMETERY or CREMATORY <b>New Cathedral</b>	
27. DATE REC'D BY HEALTH DEPT. <b>DEC 12 1972</b>				28. NAME OF REGISTRAR <b>William P. Mulloy</b>		29. FUNERAL DIRECTOR <b>H. W. Jenkins &amp; Sons Co.</b>	
30. ADDRESS <b>4905 York Road Balto., Md. 21212</b>				31. ADDRESS <b>4905 York Road Balto., Md. 21212</b>		32. ADDRESS <b>4905 York Road Balto., Md. 21212</b>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 11766		72 11766	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) <b>HARRY J. WEAVER</b>				2. DATE AND HOUR OF DEATH <b>12/10/72 10. P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> 8. COUNTY <b>U.S.A.</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>44 UNION MEMORIAL HOSPITAL</b>				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER <b>3100 ST PAUL STREET</b>			
5. SEX <b>M.</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>01-09-94</b>	9. AGE (In years last birthday) <b>78</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED VICE PRES.</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>PREST-O-LITE CO</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>WEAVER</b>			
14. MOTHER'S MAIDEN NAME <b>MARY</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES WWII</b>			
16. SOCIAL SECURITY NO. <b>215 01 4865</b>				17. INFORMANT <b>FRANK HERRLEIN</b>			
18. CAUSE OF DEATH <b>412.4 I</b>				ADDRESS <b>1633 GLENLEAGUE ROAD</b>			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <b>II</b>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Pneumonia</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>C.V.A.</b>				(B) DUE TO, OR AS A CONSEQUENCE OF: <b>C.V.A.</b>		<b>3 wks.</b>	
(C) <b>ASCVD.</b>							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>12/8</b> 19 <b>72</b> to <b>12/10</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>12/10</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Carlos H. Santillan</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>12/10/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>CARLOS H. SANTILLAN</b>				23D. ADDRESS <b>THE UNION MEMORIAL HOSP BALTO, MARYLAND 21218</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-14-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 12 1972</b>		25B. NAME OF REGISTRAR <b>[Signature]</b>		25C. FUNERAL DIRECTOR <b>Henry W. Jenkins Sons</b>			
				ADDRESS <b>4905 York Rd. Baltimore, Md. 21212</b>			



100-200000

100-200000

100-200000

100-200000

100-200000

100-200000

100-200000

100-200000

100-200000

100-200000

100-200000

100-200000

100-200000

100-200000

100-200000

100-200000

100-200000

100-200000

100-200000

100-200000

100-200000

100-200000

100-200000

100-200000

100-200000

100-200000

100-200000

100-200000

T-413

72 11767

STATE OF MARYLAND-DEATH

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 11767

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>James Talbott</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month <b>12</b> Day <b>8</b> Year <b>72</b> Estimated <input type="checkbox"/> <b>12</b> <b>8</b> <b>72</b>		Hour <b>7:20 A. M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>University Hospital</b>		3. DATE PRONOUNCED DEAD Month <b>12</b> Day <b>8</b> Year <b>72</b>		Hour <b>7:20 A. M.</b>	
6. SEX <b>Male</b>		7. RACE <b>White</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>12/16/1912</b>		10. AGE (In years last birthday) <b>59</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Francis Boswell Talbott</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supervisor</b>	
15. MOTHER'S MAIDEN NAME <b>Grayson M. Blackwell</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>218-01-0544</b>	
18. INFORMANT <b>Mrs Marjorie Talbott</b>		19. CAUSE OF DEATH <b>Multiple injuries</b>		20. DATE OF OPERATION <b>12/11/72</b>	
21. ADDRESS <b>Rose Haven, Md</b>		22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>		23. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>St. Rte. 261 - 50' S. of Birch Ave.</b>	
24. TIME (Month) (Day) (Year) (Hour) <b>11 21 72 5:00P.m.</b>		25. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		26. HOW DID INJURY OCCUR? <b>Driver of auto into fixed object</b>	
27. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		28. DATE <b>12/11/72</b>		29. NAME OF CEMETERY or CREMATORY <b>St. James Church Cemetery</b>	
30. LOCATION (City, town, or county) (State) <b>Lothian, A.A. Md.</b>		31. DATE REC'D BY HEALTH DEPT. <b>DEC 12 1972</b>		32. NAME OF REGISTRAR <b>William P. Mulloy, M.D.</b>	
33. FUNERAL DIRECTOR <b>BUCHANA N. FUNERAL HOME, Owings, Md.</b>		34. DATE <b>12/11/72</b>		35. NAME OF REGISTRAR <b>William P. Mulloy, M.D.</b>	
36. FUNERAL DIRECTOR <b>BUCHANA N. FUNERAL HOME, Owings, Md.</b>		37. DATE <b>12/11/72</b>		38. NAME OF REGISTRAR <b>William P. Mulloy, M.D.</b>	

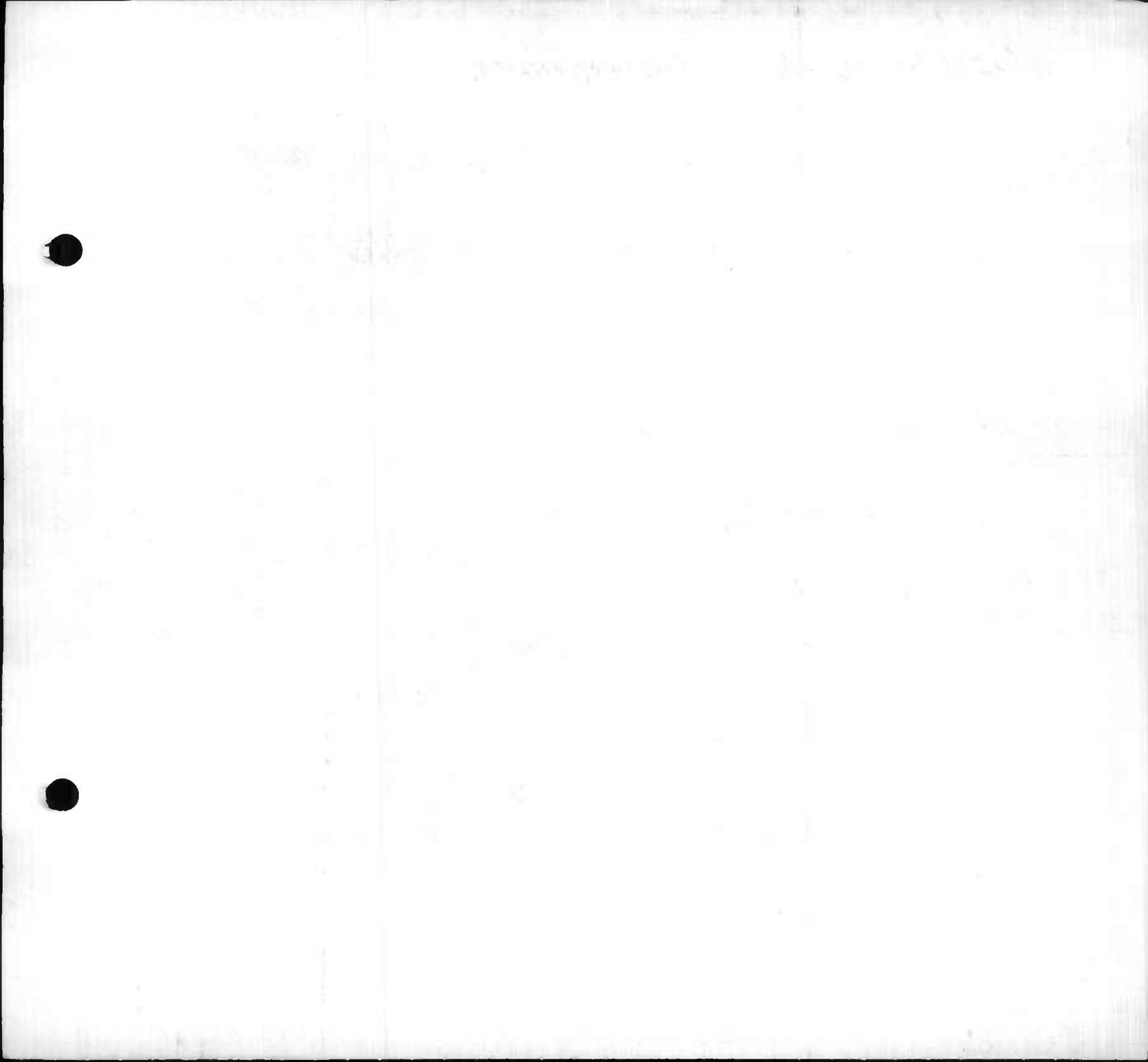


*[Faint, illegible text, likely bleed-through from the reverse side of the page.]*

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

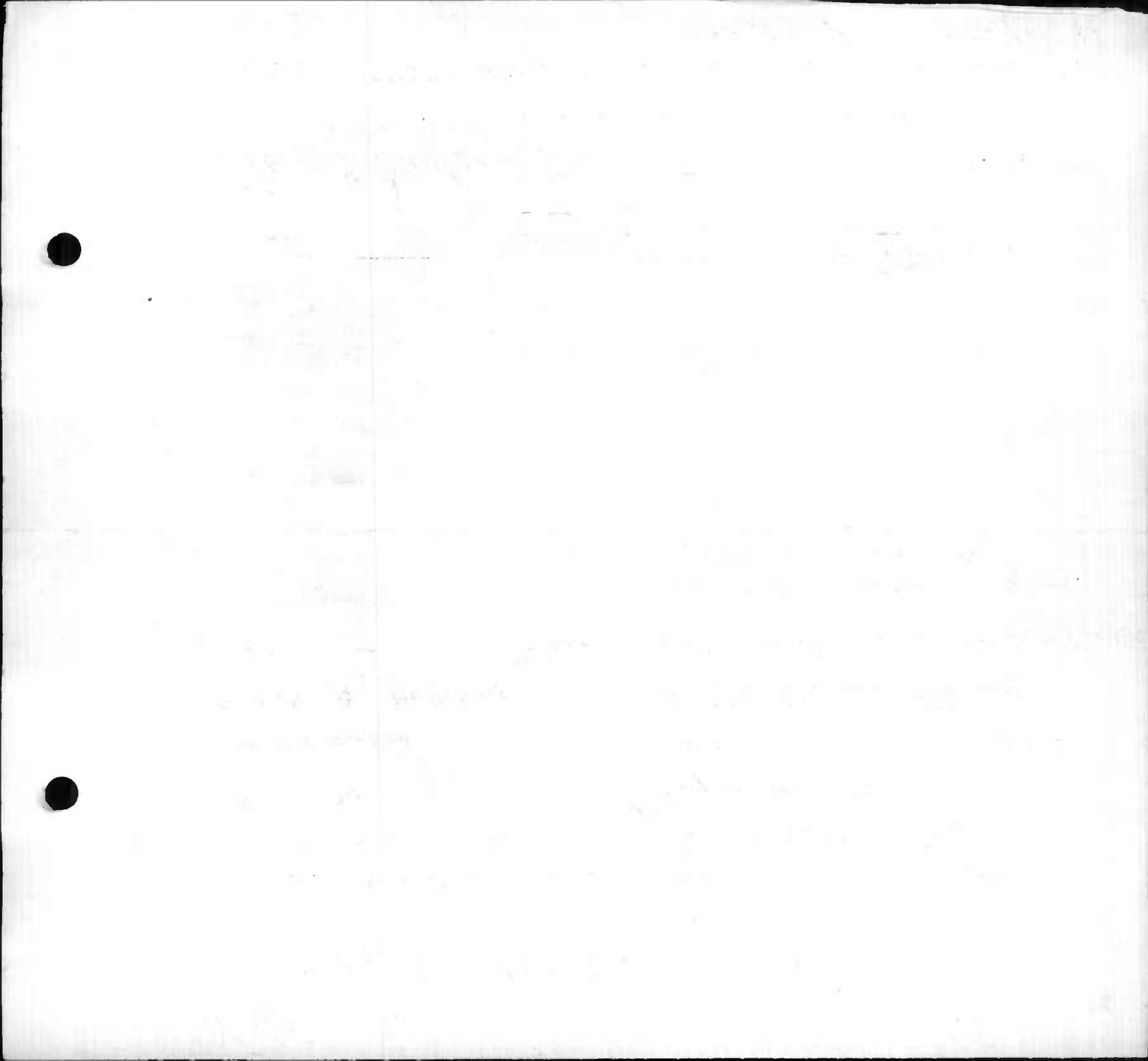
U-500		BALTIMORE CITY HEALTH DEPARTMENT		72 11768	
BIRTH NO.		72 11768		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		REG. NO. STATE OF MARYLAND-DEATH	
Anna H. Wayne		12/8/72		9 <sup>10</sup> P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		Maryland Baltimore 1903		C. CITY OR TOWN D. INSIDE CITY LIMITS?	
90 Caton Manor Nursing Home		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER		1623 Ramsey			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	MAY 3, 1888	84	Housework
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housework		own Home		Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
John Eckert		Louise Rathgeber			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		213-74-4028		Frank Piller 1263 Maple Ave.	
18. 410,9+1 230.9		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Myocardial infarction sudden	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(B) Anteriosclerotic CVD			
ANTECEDENT CAUSES		(C) _____			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Diabetes mellitus 2 Basal cell CA, left eye, extensive	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>			
22. I certify that (1) (this hospital) attended the deceased from 7/4 1967 to 12/8 1972		that (1) (we) lost saw the deceased alive on 12/8 1972		and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.	
23A. SIGNATURE		23B. DATE SIGNED			
Robert J. Levickas, M.D.		12/11/72			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Dr. Hebert J. Levickas		5504 East Drive			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		12/11/72		Western Cemetery	
24D. LOCATION (City, town, or county)		24E. LOCATION (State or foreign country)		24F. LOCATION (City, town, or county)	
Baltimore, Maryland		Baltimore, Maryland		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
DEC 12 1972		An Brose		1328 Sulphur Sp Rd	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-425		72 11769		BALTIMORE CITY HEALTH DEPARTMENT		72 11769	
CERTIFICATE OF DEATH				REG. NO. 72 11769 STATE OF MARYLAND-DEPT. OF HEALTH			
1. NAME OF DECEASED (Type or Print) <b>MARY S. MULLIKIN</b>				2. DATE AND HOUR OF DEATH <b>12/8/72</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>90 220 HOMewood TERRACE BALTIMORE, Md.</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md</b> B. COUNTY <b>1202</b>			
5. SEX <b>F</b>		6. RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 10, 1900</b>	
9. AGE (In years last birthday) <b>72</b>		10. UNDER 1 Yr. Months: Days: Hours: Min.		11. BIRTHPLACE (State or foreign country) <b>BALTO</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NEVER WORKED</b>				10B. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <b>FRANK A. MULLIKIN</b>				14. MOTHER'S MAIDEN NAME <b>BETTIE SIMONS JOHNSON</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>220440224</b>		17. INFORMANT <b>BETTIE M. WOESSNER</b>	
18. CAUSE OF DEATH <b>133.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>ADENOCARCINOMA OF THE CECUM WITH GENERALIZED METASTASIS</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>2 YRS.</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b>			
19A. DATE OF OPERATION <b>12/3/01</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (the hospital) attended the deceased from <b>December 19 69</b> to <b>December 8, 19 72</b> that (I) (we) last saw the deceased alive on <b>December 6, 19 72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (We) (did not) view the body after death.			
23A. SIGNATURE <b>Lloyd E. Saylor M.D.</b>				23B. DATE SIGNED <b>Dec. 8, 1972</b>		23C. PHYSICIAN'S NAME (Type) <b>Lloyd E. Saylor, M. D.</b>	
23D. ADDRESS <b>3902 Greenmount Avenue</b>				24A. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>			
24B. DATE <b>12/11/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>DAVID RIDGE CEM</b>		24D. LOCATION (City, town, or county) (State) <b>Reistertown Rd Pikesville Md</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 12 1972</b>	
25B. NAME OF REGISTRAR <b>Anthony [illegible]</b>		25C. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld</b>		25D. ADDRESS <b>6500 York Rd</b>		25E. DATE OF DEATH <b>12/8/72</b>	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 11770		STATE OF MARYLAND - DEATH	
BIRTH NO. 72 11770				1. NAME OF DECEASED (Type or Print) MARY WHITFIELD		2. DATE AND HOUR OF DEATH DECEMBER 4, 1972 6:05 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				A. STATE Maryland		B. COUNTY 1608	
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3920 Flowerton Road 21229			
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 12, 1899	9. AGE (In years last birthday) 73	10. Under 1 Yr. Months: Days:	11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) VA.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME (Sidney) William Bradley				14. MOTHER'S MAIDEN NAME EVA Pope			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 224-30-4317T		17. INFORMANT BCH: Records 4940 Eastern Avenue Baltimore, Maryland 21224	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: pneumonia 2 days			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) —							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). CHF, permanent demand pacemaker							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12-3 19 72 to 12-4 19 72, that (I) (we) last saw the deceased alive on 12-4 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Herbert G. Markley M.D.				23B. DATE SIGNED 12-4-72			
23C. PHYSICIAN'S NAME (Type) Herbert G. Markley, M.D.				23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 12-9-72		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State) SUFFOLK, VA.	
25A. DATE REC'D BY HEALTH DEPT. DEC 13 1972		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Elliott Funder		ADDRESS Home 1129 N. Caroline St.	

1771

1771

1771

1771

1771

1771

1771

1771

1771

FUNERAL DIRECTOR: IMPORTANT

121 00 22

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

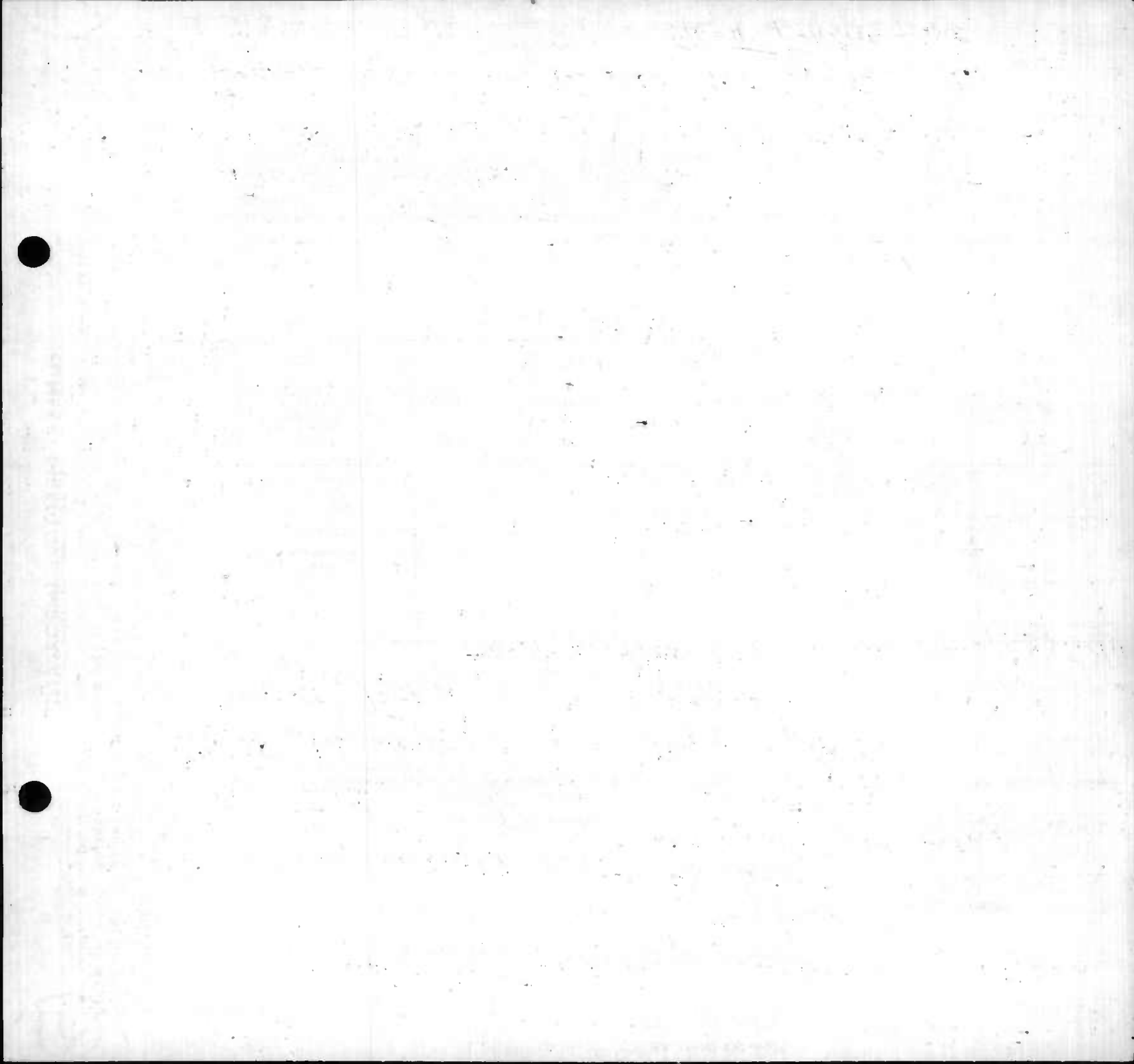
BALTIMORE CITY HEALTH DEPARTMENT				72 11771		72 11771	
BIRTH NO. W-452				72 11771		REG. NO. 72 11771	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
S. George Williams				12/8/72 0-8:30 AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
33 The Johns Hopkins Hospital				Maryland			
5. SEX Male				6. RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Custodian				1023 N. Washington Street		Md.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
UNKNOWN				UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				Robert Williams-1023 N. Washington St		1023 N. Washington St	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				(B) Chronic Coronary Artery Disease			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0		—		No		—	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)	
No		None		None		—	
21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?		22. I certify that (1) this hospital) attended the deceased from		12-7-1972 to 12-8-1972	
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		—		that (1) we last saw the deceased alive on		12-8-1972 and that in (my) (our) opinion death occurred on the date	
—		—		and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.		—	
23A. SIGNATURE				23B. DATE SIGNED		12-8-72	
J.W. Richardson M.D. DEGREE				23C. PHYSICIAN'S NAME (Type)		J.W. Richardson	
23D. ADDRESS				23E. DATE REC'D BY HEALTH DEPT.		23F. NAME OF REGISTRAR	
The Johns Hopkins Hospital				DEC 13 1972		—	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		12-13-72		Md. National Mem. Park		Laurel, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS		—	
DEC 13 1972		—		Elliott Funeral Home-1129 N. Caroline St.		—	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
T-650 72 11772					REG. NO. 72 11772				
BIRTH NO.					STATE OF MARYLAND-DHMH				
1. NAME OF DECEASED (Type or Print) <u>Raymon T. Torain</u>					2. DATE AND HOUR OF DEATH <u>12-11-72</u> <u>9:20 A.M.</u>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2759</u>				
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>1001 Springfield Ave.</u>					C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				
5. SEX <u>M.</u> 6. RACE <u>BLK.</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>3-13-1920</u> 9. AGE (In years last birthday) <u>52</u>				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Night Club Owner</u>					11. BIRTHPLACE (State or foreign country) <u>Roxboro, N.C.</u>				
13. FATHER'S NAME <u>Monroe Torain</u>					14. MOTHER'S MAIDEN NAME <u>Unknown</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>190-14-8454</u>				
17. INFORMANT <u>Esther Torain</u>					ADDRESS <u>1001 Springfield</u>				
18. <u>15791</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					CAUSE OF DEATH				
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiac failure</u>				
ANTECEDENT CAUSES					(B) <u>Carcinoma of</u> DUE TO, OR AS A CONSEQUENCE OF: <u>unknown</u>				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(C) <u>Carcinoma of pancreas</u>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>diabetes mellitus</u>									
19A. DATE OF OPERATION <u>28 Nov 1972</u>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Abdominal mass, wt. loss</u>				
20A. AUTOPSY? (Yes or No)					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)					21E. INJURY OCCURRED				
21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (this hospital) attended the deceased from <u>28 Nov.</u> 1972 to <u>17 Dec.</u> 1972, that (I) (we) last saw the deceased alive on <u>10 Dec.</u> 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Ronald H. Fishbein</u>					23B. DATE SIGNED <u>12/12/72</u>				
23C. PHYSICIAN'S NAME (Type) <u>RONALD H. FISHBEIN M.D.</u>					23D. ADDRESS <u>220 W. COLD SPRING LANE BALT 21216</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>					24B. DATE <u>12-14-72</u>				
24C. NAME OF CEMETERY OR CREMATORY <u>Arbutus Mem. Park</u>					24D. LOCATION (City, town, or county) (State) <u>Arbutus, Md.</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 13 1972</u>					25B. NAME OF REGISTRAR <u>Elliot</u>				
25C. FUNERAL DIRECTOR <u>Elliot</u>					ADDRESS <u>FUNERAL HOME</u>				





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 11773

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>JOHN H. LEE</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>00 3106 Windsor Ave.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>12 10 1972 11:30a</b> M.	
6. SEX <b>male</b>		7. RACE <b>negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>FEB 4, 1904</b>		10. AGE (in years lost birthday) <b>68</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>JOSIAH LEE</b>		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>1547</b>	
15. MOTHER'S MAIDEN NAME <b>NELLIE NELSON</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO. <b>218-192060</b>		18. INFORMANT ADDRESS <b>HILDA THOMAS S/A</b>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>no</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Russell S. Fisher, M.D.</b> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>12-11-72</b> EXAMINER'S NAME (Type) ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12-14-72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>MT. AUBURN CEMETERY</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO. MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 13 1972</b>		25B. NAME OF REGISTRAR <b>J. L. BROWN + SON P.A.</b>	
25C. FUNERAL DIRECTOR <b>123 W. Montgomery ST.</b>		25D. ADDRESS	



CONGRATULATIONS

251 HAWK  
JANUARY 1952

AT 1000 HOURS JANUARY 1952

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/68

2. H. HONORARIUM W. A.

21. VOMER NO. 255. DATE NO. 21233

13-3-33

DECEMBER 3

13

20

DECEMBER 3

13

DECEMBER 3

122

NO

21. VOMER NO. 255. DATE NO. 21233

10001 COTTAGE

10001 COTTAGE

10001 COTTAGE

10001 COTTAGE

10001 COTTAGE

10001 COTTAGE

10001 COTTAGE

10001 COTTAGE

10001 COTTAGE  
10001 COTTAGE  
10001 COTTAGE

10001 COTTAGE  
10001 COTTAGE  
10001 COTTAGE

10001 COTTAGE

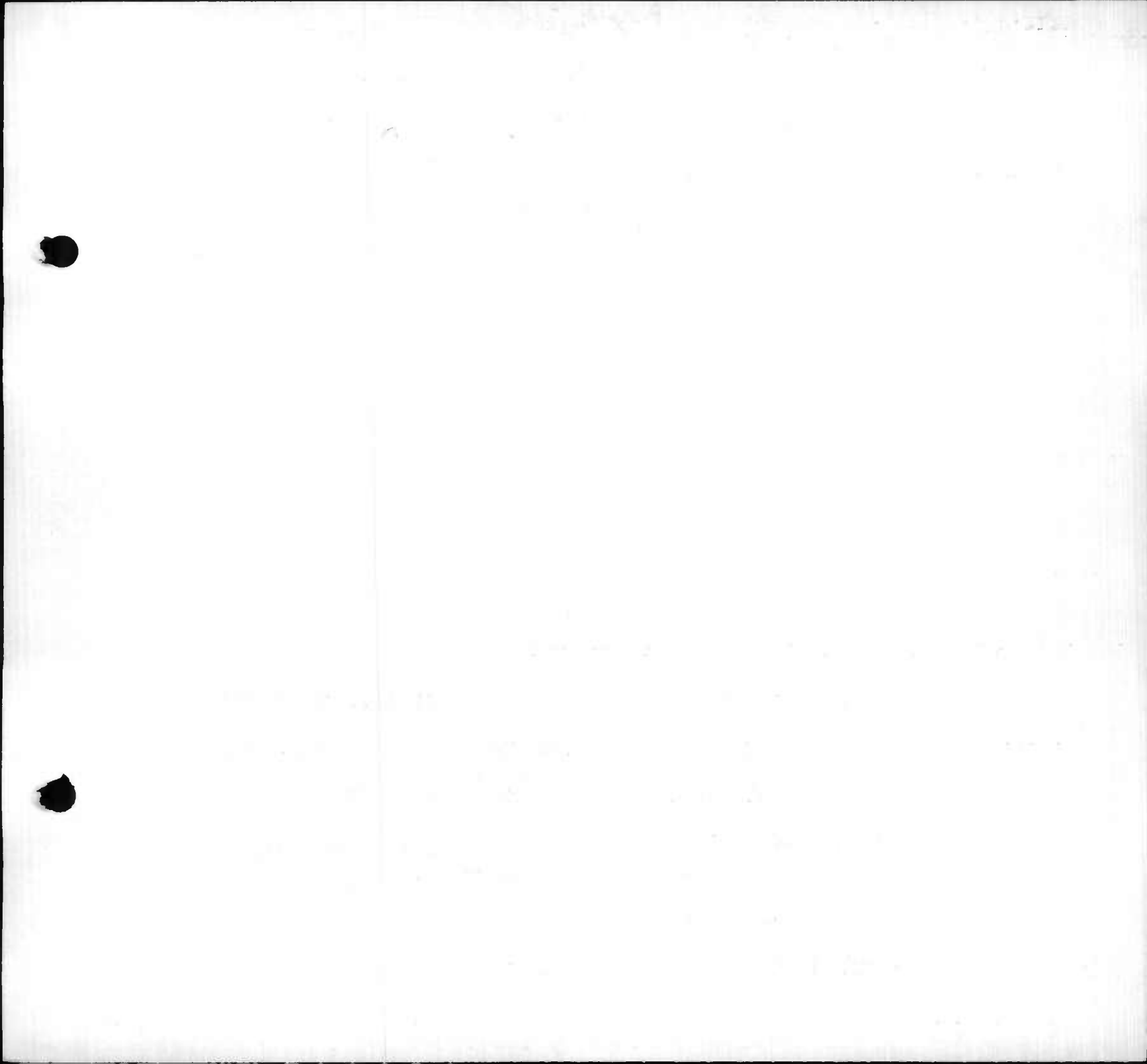
10001 COTTAGE

10001 COTTAGE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

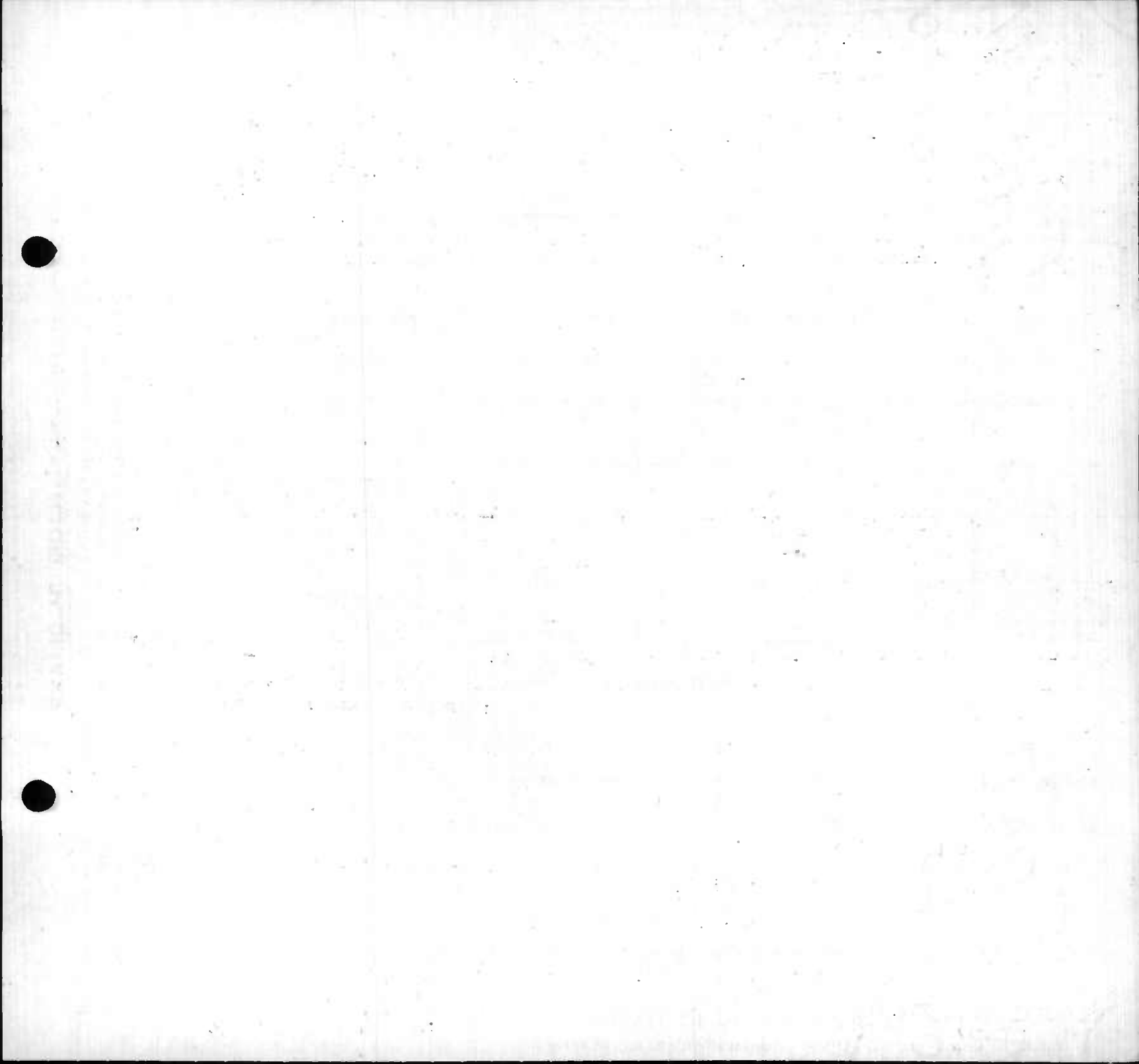
BIRTH NO.		72 11775 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 11775	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
FLORENCE E. KRACH			12/10/72 11:45 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
HOUSE IN THE PINES BEL AIRE 5837 BELAIR ROAD			MARYLAND		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			6006 SEFTON AVE.		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	9. AGE (In years last birthday)
FEMALE	WHITE	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		12/25/1879	92
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
HOUSEWIFE		OWN HOME		MARYLAND	
13. FATHER'S NAME				12. CITIZEN OF WHAT COUNTRY?	
PHILLIP GREENFIELD				U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.	
NO				216-09-2371	
17. INFORMANT				ADDRESS	
D HARRY J. KRACH				1814 WILSON PT. RD.	
18. CAUSE OF DEATH					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
NO				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 1950 to Dec. 10 1972 that (I) last saw the deceased alive on Dec. 9 1972 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
R. Donald Jandorf				12/12/72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
R. DONALD JANDORF M.D.				7403 HARFORD ROAD	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		12/13/72		PARKWOOD CEMETERY	
				24D. LOCATION (City, town, or county) (State)	
				BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
DEC 13 1972		Sidney Jandorf		ROBERT C. ALTENBURG FUNERAL HOME INC.	
				6009 HARFORD RD. BALTO., MD. 21214	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 11776		REG. NO. 72 11776	
BIRTH NO. H-165				72 11776			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Helen L. Hepbron				Dec. 12, 1972 11 p. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
00 427 E. Lake Avenue				Maryland 2712			
C. CITY OR TOWN				D. INSIDE CITY LIMITS?			
Baltimore				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER				427 E. Lake Avenue 21212			
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
F		W		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		1-10-1892 80	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Teacher				School		Mass.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Barnard Lumianski				Jeffie			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				2 16-48-4253		Mr. James M. Hepbron Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
4379 I				Cerebrovascular disease 4 hrs.			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Hypertension			
(C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0		0		No		0	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
(APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?		21G. DATE OF OPERATION	
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		0		0		0	
22. I certify that (I) (this hospital) attended the deceased from ca. 1969 19 to Dec 12 1972, that (I) (we) last saw the deceased alive on 12 Dec. 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
[Signature]				12/13/72		LOUIS P. HAMBO ROER	
23D. ADDRESS				23E. FUNERAL DIRECTOR ADDRESS			
MD-1001 St Paul & Baltimore Md-21202				Jenkins & Sons Co. 4905 York Road Balto., Md. 21212			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Cremation		12-13-72		Greenmount		Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR			
DEC 13 1972				Sidney [Signature]			

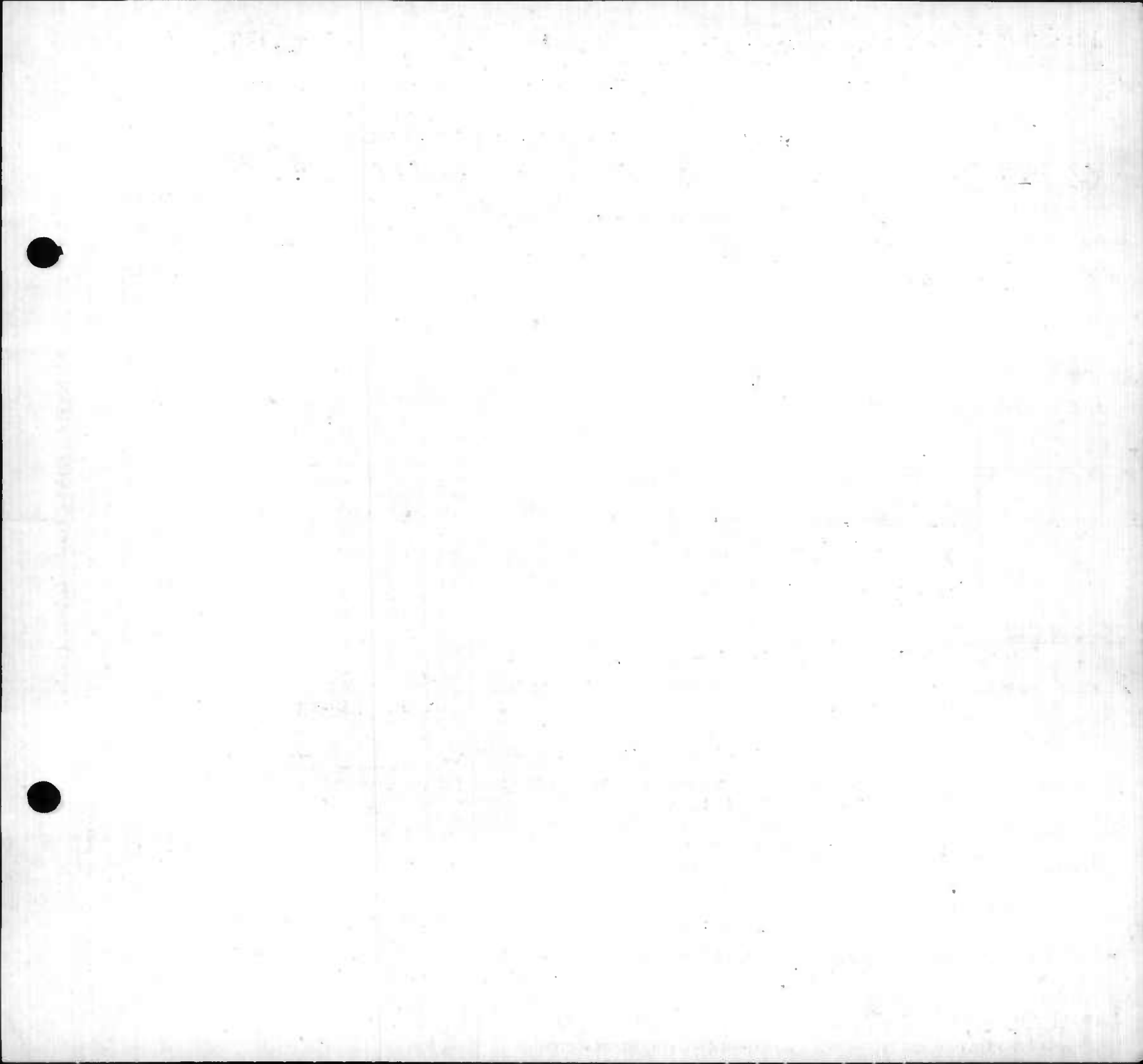




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

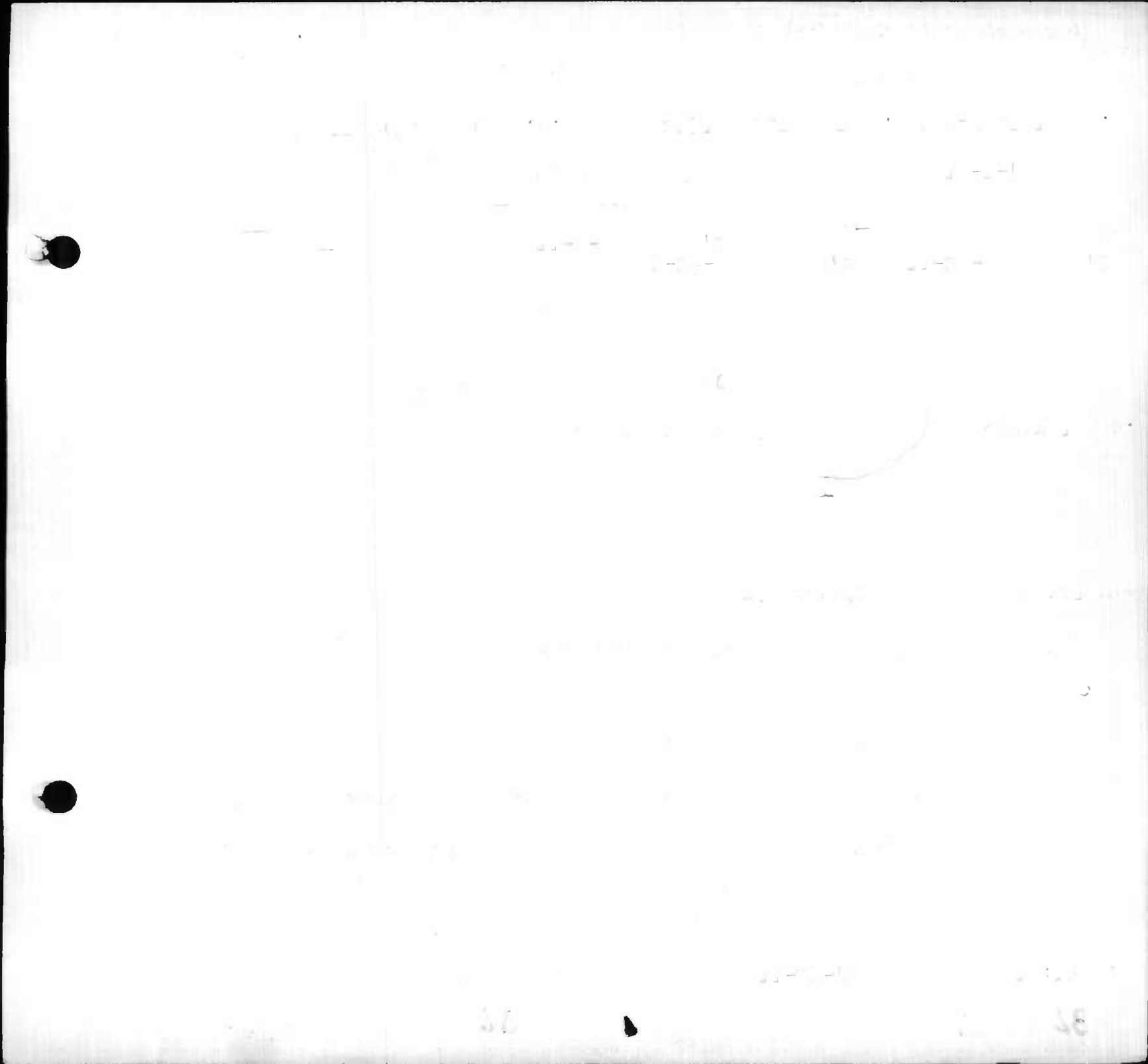
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	72 11777
72 11777				STATE OF MARYLAND, DISTRICT	
1. NAME OF DECEASED (Type or Print)		W. Glenn Hoffman		2. DATE AND HOUR OF DEATH 12 Dec 1972 6 <sup>00</sup> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2713 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 5009 Roland Avenue 21210		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-31-1897	9. AGE (In years last birthday) 75	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant		10B. KIND OF BUSINESS OR INDUSTRY Thomas-Cook Co.		11. BIRTHPLACE (State or foreign country) Penna.	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Wilson Hoffman		
14. MOTHER'S MAIDEN NAME Myrtle Parson			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 174-01-4812		17. INFORMANT Mrs. W. Glenn Hoffman		ADDRESS Same	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ACUTE HEAT ATTACK A.S.C.U.D.  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1953 to 12 Dec 72, that (I) (we) last saw the deceased alive on 10 Dec 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William G. Helfrich M.D.				23B. DATE SIGNED 13 Dec 72	
23C. PHYSICIAN'S NAME (Type) William G. Helfrich M.D.				23D. ADDRESS 5006 Roland Avenue	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 12-13-72		24C. NAME OF CEMETERY OR CREMATORY Greenmount	
24D. LOCATION Balto.		24E. (City, town, or county)		24F. (State) Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 13 1972		25B. NAME OF REGISTRAR Sidney W. Horton		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. 4905 York Road Balto.; Md. 21212	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-530		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 11778
72 11778		CERTIFICATE OF DEATH		STATE OF MARYLAND-DEPT
BIRTH NO.		1. NAME OF DECEASED Type or Print <b>Grace Smith</b>		2. DATE AND HOUR OF DEATH <b>11-29-72 10:10 A.M.</b>
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland.</b> B. COUNTY <b>1506</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Park Hill Nursing home 1802 Eutaw st</b>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <b>2772 W. North Ave</b>				
5. SEX <b>F</b>	6. RACE <b>Black</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug-25-1885</b>	9. AGE (In years last birthday) <b>87</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>218-48-4493</b>		17. INFORMANT <b>Hester Smith 2772 W. North Ave</b>
18. <b>1519 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>gastroic carcinoma</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH A. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>gastroic carcinoma</b> B. DUE TO, OR AS A CONSEQUENCE OF: C. DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>several weeks</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<b>secondary anemia</b>		<b>several mos.</b>
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) 1 Month ( ) Day ( ) Year ( ) Hour ( )		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>3-28-1972</b> to <b>11-29-1972</b> that (I) (we) last saw the deceased alive on <b>11-9-1972</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>E. Ellsworth Cook M.D.</b>		23B. DATE SIGNED <b>12-1-72</b>		
23C. PHYSICIAN'S NAME (Type) <b>E. ELLSWORTH COOK M.D.</b>		23D. ADDRESS <b>2431 MARYLAND AVE. BALTO 21218 MD.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Dec-2-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>mt Auburn</b>
24D. LOCATION <b>Balto Md.</b>		24E. CITY, TOWN, or county (State)		
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 13 1972</b>		25B. NAME OF REGISTRAR <b>Adney Weston</b>		25C. FUNERAL DIRECTOR <b>Chas. E. Hughes 1532 Hollins st.</b>
25D. ADDRESS <b>21223</b>				



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>72 11779</b>	
<b>E-534</b>		<b>72 11779</b>	
<b>CERTIFICATE OF DEATH</b>		<b>STATE OF MARYLAND-DECEASED</b>	
1. NAME OF DECEASED (Type or Print) <b>ENTLER, MARTIN HAROLD</b>		2. DATE AND HOUR OF DEATH <b>NOVEMBER 21 1972 10:50 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>VETERANS ADMINISTRATION HOSPITAL</b> <b>3900 LOCH RAVEN BOULEVARD</b> <b>BALTIMORE, MARYLAND 21218</b>		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>MALE</b> 6. RACE <b>CAUCASIAN</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>4-5-07</b> 9. AGE (In years last birthday) <b>65</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ELECTRICIAN</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>UNKNOWN</b>	
11. BIRTHPLACE (State or foreign country) <b>LOS ANGELES, CALIF.</b>		12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	
13. FATHER'S NAME <b>MARTIN EDWARD ENTLER</b>		14. MOTHER'S MAIDEN NAME <b>EFFIE HARRIETT LEWIS</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <b>YES 12-5-42 to 7-22-45</b>		16. SOCIAL SECURITY NO. <b>568-01-07-41</b>	
17. INFORMANT <b>VA HOSPITAL RECORDS</b> ADDRESS <b>3900 LOCH RAVEN BLVD, BALTIMORE, MD. 21218</b>			
18. I <b>571.01</b>		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>RUPTURED ESOPHAGEAL VARICES</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Portal Hypertension</b>		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) <b>Alcoholic Cirrhosis</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that <b>he</b> (this hospital) attended the deceased from <b>NOVEMBER 15 1972</b> to <b>NOVEMBER 21 1972</b> , that <b>we</b> last saw the deceased alive on <b>NOVEMBER 21 1972</b> and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>we</b> (We) (did) <b>not</b> view the body after death.			
23A. SIGNATURE <b>Mark H. Kasowitz</b>		23B. DATE SIGNED <b>11/27/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>MARK H. KASOWITZ, M.D.</b>		23D. ADDRESS <b>VA HOSPITAL</b> <b>3900 LOCH RAVEN BLVD, BALTIMORE, MD. 21218</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>Dec-12-72 mt calvary</b>	
<b>Cedar Hill Rd. Baltimore Md</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 13 1972</b>		25B. NAME OF REGISTRAR <b>Anthony W. Boston</b>	
25C. FUNERAL DIRECTOR <b>Charles Hughes</b>		ADDRESS <b>1532 Hollins st</b>	

JOHN A. HARRIS, JR. - 1000 10th St. N.W. - Washington, D.C.

JOHN A. HARRIS, JR.

HARRIS

THE HARRIS FIRM

WASHINGTON, D.C.

JOHN A. HARRIS, JR. - 1000 10th St. N.W. - Washington, D.C.

JOHN A. HARRIS, JR. - 1000 10th St. N.W. - Washington, D.C.

JOHN A. HARRIS, JR. - 1000 10th St. N.W. - Washington, D.C.

JOHN A. HARRIS, JR. - 1000 10th St. N.W. - Washington, D.C.

JOHN A. HARRIS, JR. - 1000 10th St. N.W. - Washington, D.C.

JOHN A. HARRIS, JR. - 1000 10th St. N.W. - Washington, D.C.

JOHN A. HARRIS, JR. - 1000 10th St. N.W. - Washington, D.C.

JOHN A. HARRIS, JR. - 1000 10th St. N.W. - Washington, D.C.

C-223

72-11780

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO.

72-11780

STATE OF MARYLAND-DEPT

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Chichester, Herman F.

2. DATE AND HOUR OF DEATH

12/8/72 9:59 AM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

4940 Eastern Ave

Baltimore, Maryland 21224

Baltimore City Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)

A. STATE

B. COUNTY

Md

Baltimore

5300

C. CITY OR TOWN

Baltimore 21219

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

2525 Lodge Forest Drive

5. SEX

Male

6. RACE

Caucasian

7. MARRIED

NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

6-23-84

9. AGE (in years  
last birthday)

88

10. Under 1 Yr. 11. Under 24 Hrs.

Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

MASTER Hunter

10B. KIND OF BUSINESS OR INDUSTRY

Hunting

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

William D Chichester

14. MOTHER'S MAIDEN NAME

Mary E. Ford

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown)

unknown

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

226-42-4077A

17. INFORMANT

P. H. T. T. Records: BCH-4940 Eastern Avenue

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) slowing the  
UNDERLYING CONDITION lost.

CAUSE OF DEATH

Bronchopneumonia

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

Gram negative streptococcus

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

1 hr

2 hrs

11 days

13 days

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

FRAILTY of old (two)

19A. DATE OF OPERATION

None

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

None

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

(If in Baltimore City, give exact location)

None reported

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)☐21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Home

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

At home in Baltimore

21D. TIME  
OF INJURY  
(APPROX.)

11/25/72

21E. INJURY OCCURRED

While At

Work ☐

Not While

At Work ☒

21F. HOW DID INJURY OCCUR?

Fell Down STAIRS

22. I certify that (I) (this hospital) attended the deceased from 11/25/72 to 12/8/72  
that (I) (we) last saw the deceased alive on 12/8/72 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

R. Sylvan MD

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

12/8/72

23C. PHYSICIAN'S  
NAME (Type)

R. Sylvan

MD

23D. ADDRESS

4940 Eastern Avenue, Baltimore, Md.

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

12/12/72

24C. NAME OF CEMETERY or CREMATORY

Mount Comfort Cemetery

24D. LOCATION

(City, town, or county)

Alexandria, Virginia

(State)

25A. DATE REC'D BY HEALTH DEPT.

DEC 13 1972

25B. NAME OF REGISTRAR

Sidney Johnston

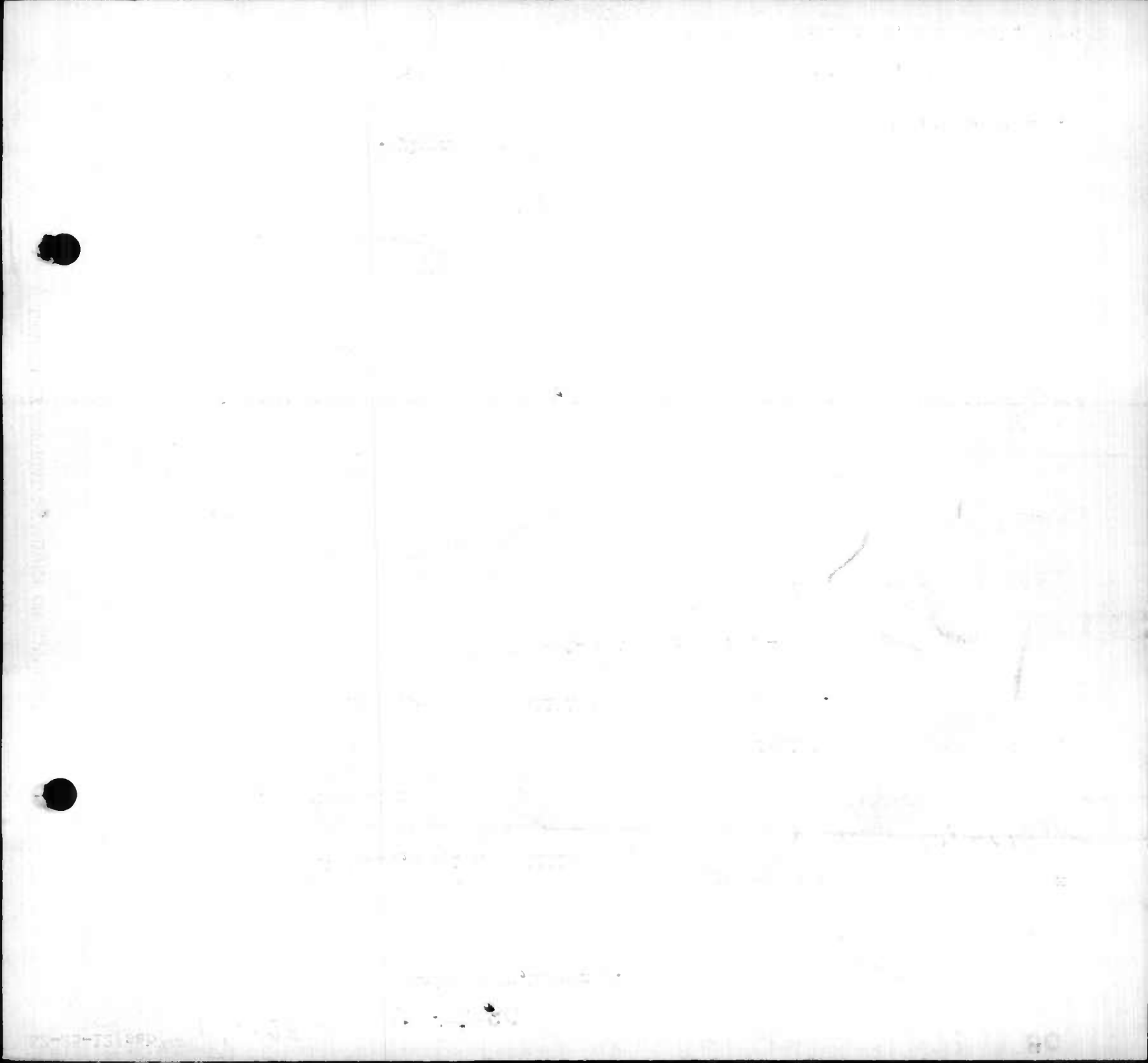
25C. FUNERAL DIRECTOR

Demaine Funeral Home, Alexandria, Virginia

ADDRESS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>72 11781</u>	
<b>1. NAME OF DECEASED</b> (Type or Print) <u>LOUISE J. JOINER</u>		<b>2. DATE AND HOUR OF DEATH</b> <u>DEC 8th 11.58 P.M.</u>					
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>THE UNION MEMORIAL HOSPITAL</u>				<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <u>MISSISSIPPI</u> B. COUNTY <u>21</u> <b>C. CITY OR TOWN</b> <u>MERIDIAN</u> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <u>4710 PAULING STREET</u>			
<b>5. SEX</b> <u>F</u>	<b>6. RACE</b> <u>W</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>6/21/1905</u>	<b>9. AGE</b> (In years, last birthday) <u>67</u> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>PROOF READER</u>
<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <u>NEWSPAPER</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>MISSISSIPPI</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>W. EDGAR JACKSON</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>WALKER SANFORD</u>			
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				<b>16. SOCIAL SECURITY NO.</b> <u>427-64-9767</u>		<b>17. INFORMANT</b> <u>MR. JERRY JOINER</u>	
<b>18. CAUSE OF DEATH</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>ACUTE MYOCARDIAL INFARCTION</u> <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ARTERIOSCLEROSIS</u>				<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>							
<b>19A. DATE OF OPERATION</b> <u>0</u>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)		<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)			
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>			
<b>22. I certify that (I) (this hospital) attended the deceased from <u>DEC 8th 1972</u> to <u>DEC 8th 1972</u>, that (I) (we) last saw the deceased alive on <u>DEC 8th 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>							
<b>23A. SIGNATURE</b> <u>[Signature]</u>				<b>Attending Phys.</b> <input type="checkbox"/> <b>Med. Director</b> <input type="checkbox"/> <b>Staff Phys.</b> <input type="checkbox"/>		<b>23B. DATE SIGNED</b>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <u>ANDRES E. SUAREZ, MD</u>				<b>23D. ADDRESS</b>			
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>		<b>24B. DATE</b> <u>12/12/72</u>		<b>24C. NAME OF CEMETERY OR CREMATORY</b> <u>MAGNOLIA</u>		<b>24D. LOCATION</b> (City, town, or county) (State) <u>MERIDIAN, MISS.</u>	
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>DEC 13 1972</u>		<b>25B. NAME OF REGISTRAR</b> <u>[Signature]</u>		<b>25C. FUNERAL DIRECTOR</b> <u>W. Brooks Buckley, Dundalk, Md.</u>		<b>ADDRESS</b>	



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>5-354</u>		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>72 11782</u>	
1. NAME OF DECEASED (Type or Print) <u>STANLEY, Cynthia (mother)</u>		2. DATE AND HOUR OF DEATH <u>12/6/72 12:45 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>BALT. CITY HOSP.</u> 4940 Eastern Avenue, Baltimore, Md. 21224		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>DORCHESTER</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>BALT. CITY HOSP.</u>		C. CITY OR TOWN <u>CAMBRIDGE</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER <u>834 PARK LANE</u>		21613			
5. SEX <u>MALE</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/5/72</u>	9. AGE (In years last birthday) <u>12</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. <u>12</u> <u>26</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME			
14. MOTHER'S MARRIED NAME <u>STANLEY CYNTHIA L. ABOVE</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT <u>HOSP. CHART FROM CAMBRIDGE MD</u>			
18. <u>726.21</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>ANOXIA</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>RESPIRATORY DISTRESS SYNDROME</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>PREMATURITY</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12:45 PM, 12/5/72</u> to <u>12:45 AM, 12/6/72</u> that (I) (we) last saw the deceased alive on <u>12/5/72</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>G. H. Lambert, MD</u>		23B. DATE SIGNED <u>12/6/72</u>		23C. PHYSICIAN'S NAME (Type) <u>G.H. Lambert, MD</u>	
23D. ADDRESS <u>BALTIMORE CITY HOSP.</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>			
24B. DATE <u>12-7-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Baltimore City Hospitals</u>		24D. LOCATION (City, town, or county) (State) <u>4940 Eastern Ave Balto. Md. 21224</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 13 1972</u>		25B. NAME OF REGISTRAR <u>Sidney [Signature]</u>		25C. FUNERAL DIRECTOR <u>HOSPITAL DISPOSAL</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72-11783		72-11783	
BIRTH NO.				STATE OF MARYLAND - DEPT.			
1. NAME OF DECEASED (Type or Print) <b>WALKER, FLORENCE E.</b>				2. DATE AND HOUR OF DEATH <b>12/11/72 1:50 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Union Memorial Hospital</b>				A. STATE <b>MARYLAND</b>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				B. COUNTY <b>1306</b>			
C. CITY OR TOWN <b>BALTIMORE</b>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <b>822 W. 34th Street</b>							
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>07-25-81</b>	9. AGE (In years last birthday) <b>91</b>	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>GEORGE Caldwell</b>			14. MOTHER'S MAIDEN NAME <b>XXXXXXXXXX Ryan</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>215-54-2037</b>		17. INFORMANT <b>ELMER G. WALKER (son)</b>		
18. <b>4367 I</b>			CAUSE OF DEATH			ADDRESS <b>SAME</b>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Possible C.V.A.</b>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>DU, T. I. Dehydration (3) MALNUTRITION</b>			(C) DUE TO, OR AS A CONSEQUENCE OF:				
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>12-06-</b> 19 <b>72</b> to <b>12-11-</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>12-11-</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Luis Sirotzky M.D.</b>						23B. DATE SIGNED <b>12/11/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Luis Sirotzky M.D.</b>						23D. ADDRESS <b>U. M. H.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/14/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 13 1972</b>		25B. NAME OF REGISTRAR <b>Edmund H. Hinton</b>		25C. FUNERAL DIRECTOR <b>A. Alan Seitz, Jr. - 3818 Roland Ave.</b>			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH											
M-520 72 11704		REG. NO. 72 11704		STATE OF MARYLAND-DEATH							
1. NAME OF DECEASED (Type or Print) <b>HAZEL Z. MEINKE</b>				2. DATE AND HOUR OF DEATH <b>DEC 10, 1972 4:10 A.M.</b>							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>MARYLAND GENERAL HOSPITAL</b> <b>48</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTO.</b> C. CITY OR TOWN <b>BALTO.</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>6440 LEHNERT SR.</b>							
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/7/04</b>	9. AGE (In years last birthday) <b>68</b>	If Under 1 Yr. Months: Days: Hours: Min.					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>OHIO</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>HUEY</b>				14. MOTHER'S MAIDEN NAME <b>Zepha Stormes</b>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNKNOWN</b>				16. SOCIAL SECURITY NO. <b>820026980</b>		17. INFORMANT <b>CARL CHART MEINKE</b> ADDRESS <b>6440 Lehnert St.</b>					
18. <b>209X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>208-05-5872</b>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>lung abscess</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>?</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <b>Myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF:				<b>?</b>			
(C) _____											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION <b>12/10</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <b>11/13</b> 19 <b>72</b> to <b>12/10</b> 19 <b>72</b> that (2) (we) last saw the deceased alive on <b>12/10</b> 19 <b>72</b> and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <b>H. Yun, M.D.</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>12/10/72</b>			
23C. PHYSICIAN'S NAME (Type) <b>Hyo-Yun Yun, M.D.</b>				23D. ADDRESS <b>Maryland General Hospital</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>				24B. DATE <b>12/13/72</b>		24C. NAME of CEMETERY or CREMATORY <b>Lorraine Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 13 1972</b>				25B. NAME OF REGISTRAR <b>Adeline Johnston</b>				25C. FUNERAL DIRECTOR <b>John T. Stansbury, Jr.</b> ADDRESS <b>6411 Windsor Mill Rd. 21207</b>			

100-100000

## CERTIFICATE OF DEATH

REG. NO. 72 11785

STATE OF MARYLAND-DEATH

BIRTH NO. M-635

1. NAME OF DECEASED  
(Type or Print)MARTIN, MARY ANN (KNOWN AS  
SISTER LORETTO MARTIN) DC

2. DATE AND HOUR OF DEATH

DECEMBER 9, 1972 8:30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

ST AGNES HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN

EMITTSBURG

D. INSIDE CITY LIMITS?

YES ☐NO ☒E. STREET AND NUMBER VILLA ST. MICHAEL  
ST JOSEPH PROVINCIAL HOUSE

5. SEX

FEMALE

6. RACE

CAUCASIAN

7. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

11-21-88

9. AGE (In years  
last birthday)

84

If Under 1 Yr.

Months: Days: Hours: Min.

If Under 24 Hrs.

Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

RELIGIOUS

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

IRELAND

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

HENRY MARTIN

14. MOTHER'S MAIDEN NAME

ELLEN (MORRIS)

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

219540655

17. ADDRESS

CATON AVES. BALTO; MD. 21229  
ST AGNES HOSPITAL RECORDS-WILKENS &

18.

410.9 I

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At ☐  
WorkNot While ☐  
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that ~~XX~~ this hospital attended the deceased from DEC. 6 1972 to DEC. 9 1972  
that ~~XX~~ (we) last saw the deceased alive on DEC. 9 1972 and that in ~~XX~~ (our) opinion death occurred on the date  
and hour and from the causes stated above ~~XX~~ (we) (did) (XXXX) view the body after death.

23A. SIGNATURE

Benavides M.D.

DEGREE

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

12-9-72

23C. PHYSICIAN'S  
NAME (Type)

VICTOR BENAVIDES, M.D.

DEGREE

23D. ADDRESS

ST AGNES HOSPITAL BALTO MD 21229

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

12-12-72

24C. NAME OF CEMETERY or CREMATORY

St. Joseph Cem.

24D. LOCATION

(City, town, or county)

Emmitsburg, Md

25A. DATE REC'D BY HEALTH DEPT.

DEC 13 1972

25B. NAME OF REGISTRAR

Sidney H. Hinton

25C. FUNERAL DIRECTOR

Charles Wilson Emmitsburg Md.

ADDRESS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

ALCANTARA, BERNARDES, A.O.

31 JAMES HOSKINS, 2120 NO 3150

11-1-10

XX - - - - - XXX

XX

DEC

31

XX

XX - - - - -

DEC 31 1910

31 1910

30

31 JAMES HOSKINS, 2120 NO 3150

31 JAMES HOSKINS, 2120 NO 3150

RECEIVED

31 JAMES HOSKINS, 2120 NO 3150  
31 JAMES HOSKINS, 2120 NO 3150  
31 JAMES HOSKINS, 2120 NO 3150

RECEIVED

RECEIVED

11-1-10

RECEIVED

11-1-10

31 JAMES HOSKINS, 2120 NO 3150

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

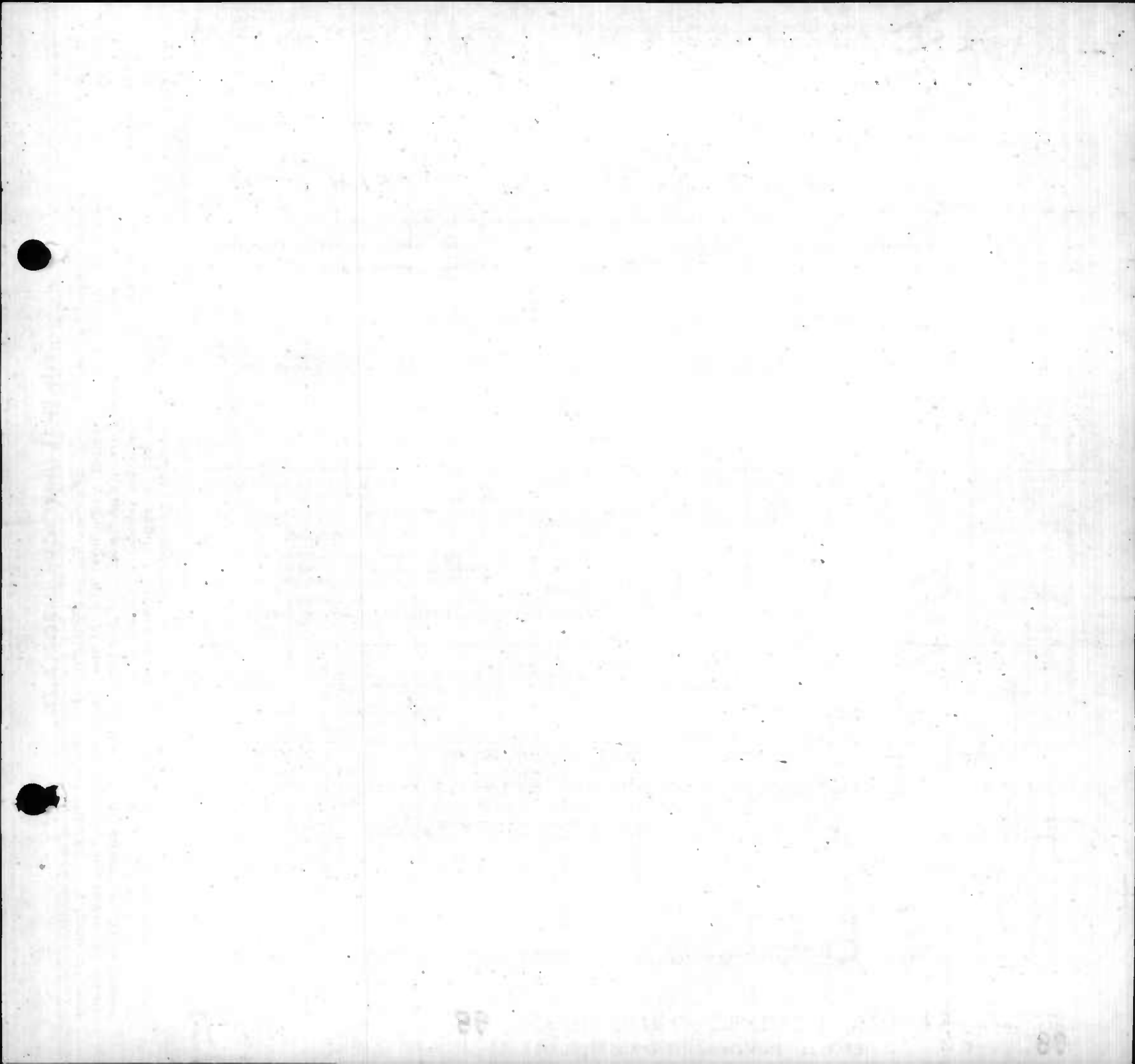
82

82

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 11786		REG. NO. 72 11786	
BIRTH NO. 1-242				72 11786		STATE OF MARYLAND - DEPT.	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Philip T. Jachelski				12/9/72 11:25 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
00 1104 Cooks La. 21229				Md. 2834			
5. SEX 6. RACE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 9. AGE (In years last birthday)			
male white				7/10/15 57			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)			
police				Balto. police dept Maryland			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Theodore Jachelski				Lillian Kantorski			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
yes WW 2				213 07 3951			
17. INFORMANT				ADDRESS			
G. Melva Jachelski				1104 Cooks La.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				Cancer of Bile Duct			
ANTECEDENT CAUSES				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				1 yr			
II				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (APPROX.)			
21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 9-5-72 to 11-17 1972, that (I) (we) last saw the deceased alive on 11-17 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				23A. SIGNATURE			
Stuart H Brager, M.D.				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Stuart H Brager, M.D.				1114 St. Paul Street, Baltimore, 21202			
24A. BURIAL CREMATION, 24B. DATE REMOVAL (Specify)				24C. NAME OF CEMETERY OR CREMATORY			
burial 12/12/72				Woodlawn Cem.			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR			
DEC 13 1972				John T. Stansbury			
25C. FUNERAL DIRECTOR				ADDRESS			
John T. Stansbury				6411 Windsor Mill Rd.			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
D-250		72 11787		72 11787	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
HAZEL MAY DIXON		Dec 10 1972 12 08 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
South Baltimore Gen. Hosp 3001 S. Hanover St		Md. 2506			
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
F		Caucasian		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH		9. AGE (in years lost birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
5-29-08		64		Housewife	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY		13. FATHER'S NAME	
USA (Md.)		USA		James E. Neal	
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
Frances Jenkins		NO		20224845	
17. INFORMANT		18. CAUSE OF DEATH			
Son Thomas Dixon		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			
5 Days		ACUTE PULMONARY EDEMA			
5 Days		SUPRAVENTRICULAR ARRHYTHMIAS			
Sev. years		(ARTERIOSCLEROTIC HEART DISEASE)			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) PNEUMONIA			
		Diabetes Mellitus			
		1 Day			
		Sev. years			
MEDICAL CERTIFICATION		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (1) (this hospital) attended the deceased from Feb 19 72 to Present 19 72 that (1) (we) last saw the deceased alive on Dec 10 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Colvin C. Carter, M.D.				Dec 10, 1972	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Colvin C. Carter M.D.				South Balto. Gen. Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		12/13/72		Glen Haven Cemetery	
24D. LOCATION (City, town, or county)		24E. NAME of FUNERAL DIRECTOR		24F. ADDRESS	
Glen Burnie, Maryland		George J. Gonce		4001 Ritchie Highway	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
DEC 13 1972		Sandra H. Hinton		George J. Gonce	



1,582

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 11788		72 11788	
CERTIFICATE OF DEATH				REG. NO.		STATE OF MARYLAND	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
Alpha Hachemeister		12/8/72 2:PM		South Baltimore 43 General Hospital		Md. 2544	
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
F		W		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11/11/14	
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
58				Georgia		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
John R Lamb				Alpha R Wright			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
NO		248054811		Robert Hachemeister 3704 St. Victor St			
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE			
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				Collagen Vascular disease			
ANTECEDENT CAUSES				DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				With pericarditis and peripheral vascular disease			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
						Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						No	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from Nov. 21 1972 to Dec. 8 1972 that (I) (we) lost saw the deceased alive on Dec. 8 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Duck Sung Chun MD							
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
DUCK SUNG CHUN							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		12/12/72		Meadowridge Cemetery		Elkridge, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
DEC 13 1972		Sandy Johnston		George S. Gonce		4001 Ritchie Highway	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) BENJAMIN F. LOWE, JR.		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 5520 Relcrest Rd.		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 10 1972 12:35p M.	
6. SEX male		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 14 Oct 43		10. AGE (In years last birthday) 29 28	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin F. Lowe, Sr.		14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 2644	
15. MOTHER'S MAIDEN NAME Naomi Andrews		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes Vietnam Conflict	
17. SOCIAL SECURITY NO. 216-42-2711		18. INFORMANT Mrs. Barbara Stanger, 516 Glen Granite	
19. 304.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE Bronchopneumonia DUE TO, OR AS A CONSEQUENCE OF: (B) Narcotics addiction DUE TO, OR AS A CONSEQUENCE OF: (C)	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE: Ronald N. Kornblum, M.D. EXAMINER'S NAME (Type)		21. AUTOPSY? (Yes or No) yes DATE SIGNED 12-11-72	
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 12 Dec 72	
24C. NAME of CEMETERY or CREMATORY Moreland Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore County, Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 13 1972		25B. NAME OF REGISTRAR Sidney Johnston	
25C. FUNERAL DIRECTOR Ullrich Funeral Home, Balto., Md.		ADDRESS	

12-20-1972 - Completion of cause of death on a pending medical examiner death certificate  
Ronald N. Kornblum, M.D. hs

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 11790	
72 11790				STATE OF MARYLAND - DEATH	
BIRTH NO. T-251		72 11790		72 11790	
1. NAME OF DECEASED (Type or Print) TSAMBARLIS, ASPASIA		2. DATE AND HOUR OF DEATH DEC. 8, 1972 12:40 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE Maryland B. COUNTY 2605			
FULL NAME OF HOSPITAL OR INSTITUTION SOUTH BALTIMORE GENERAL HOSPITAL 43		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		E. STREET AND NUMBER 605 Savage Street			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-17-99	9. AGE (In years last birthday) 73	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Greece	
12. CITIZEN OF WHAT COUNTRY? Greece		13. FATHER'S NAME George Geratzounis		14. MOTHER'S MAIDEN NAME Mary	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-36-6603		17. INFORMANT John Kepreos	
18. CAUSE OF DEATH		ADDRESS 605 Savage St, Baltimore, Md.			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebro Vascular Accident			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF: Atherosclerotic Cardiovascular Disease.			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Diabetes.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Dec. 8 19 72 to Dec. 8 19 72 that (I) (we) last saw the deceased alive on Dec. 8 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Duck Sung Chun MD				23B. DATE SIGNED Dec. 8 1972	
23C. PHYSICIAN'S NAME (Type) DUCK SUNG CHUN. M.D.				23D. ADDRESS South Balto Gen. Hosp. 3001 S. Hanover St. Balto. Md. 2123.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-11-72		24C. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	
24D. LOCATION Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. DEC 13 1972			
25B. NAME OF REGISTRAR Audrey Hinton		25C. FUNERAL DIRECTOR Nicholas T. Matthews			
25D. ADDRESS 3021 Eastern Ave., Baltimore, Md.					





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

RELEASED ON APPROVAL OF MEDICAL EXAMINER		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <u>72 11791</u>	
1. NAME OF DECEASED (Type or Print) <u>JANE E. PARKS</u>		2. DATE AND HOUR OF DEATH <u>DEC 9, 1972</u> <u>9:25 P</u>		STATE OF <u>MARYLAND</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>SINAI HOSPITAL, Baltimore, MD.</u> <u>42</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>2788</u>		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>F</u>		6. RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>2/23/82</u>		9. AGE (In years last birthday) <u>90</u>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND, ANNAPOLIS</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>William Purdy</u>		14. MOTHER'S MAIDEN NAME <u>Mary Brown</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-74-8827</u>		17. INFORMANT ADDRESS <u>Mr. Carl F. Parks, 5239 Reisterstown Rd, 21215</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>IMPACTED SUBCAPITAL FRACTURE OF LEFT HIP</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CONGESTIVE HEART FAILURE</u> (B) <u>DIABETES MELLITUS</u> DUE TO, OR AS A CONSEQUENCE OF: <u>RENAL FAILURE</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u>	
19. DATE OF OPERATION <u>12/12/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>FRACTURE HIP</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>PATIENT'S HOME</u>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>27-88</u>		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>12/6/72 1000A</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>	
21F. HOW DID INJURY OCCUR? <u>PATIENT FELL</u>		22. I certify that (1) this hospital attended the deceased from <u>12/6</u> 19 <u>72</u> to <u>12/9</u> 19 <u>72</u>		that (1) (we) last saw the deceased alive on <u>12/9</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.	
23A. SIGNATURE <u>William I. Smyth MD</u>		23B. DATE SIGNED <u>12/9/72</u>		23C. PHYSICIAN'S NAME (Type) <u>WILLIAM I. SMYTH MD</u>	
23D. ADDRESS <u>SINAI HOSPITAL</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/13/72</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Pikesville, Baltimore, Md. 21208</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 13 1972</u>	
25B. NAME OF REGISTRAR <u>Loring Byers</u>		25C. FUNERAL DIRECTOR <u>Loring Byers Funeral Directors P.A.</u>		ADDRESS <u>8728 Liberty Road, Randallstown, Md. 21133</u>	

1. *[Faint handwritten text]*

2. *[Faint handwritten text]*

3. *[Faint handwritten text]*

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 11792		REG. NO.	
BIRTH NO. B-426				72 11792		STATE OF MARYLAND-DEME	
1. NAME OF DECEASED (Type or Print) RICHARD A. Blucher				2. DATE AND HOUR OF DEATH 12-8-72 2:00 PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION MARYLAND GENERAL HOSPITAL 48				A. STATE MD			
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION				B. COUNTY 1207			
C. CITY OR TOWN BALTIMORE				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 2703 HAMPDEN AV							
5. SEX M		6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/27/81	
9. AGE (In years last birthday) 91		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BOILERMAKER		11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN				16. SOCIAL SECURITY NO. 719073111		17. INFORMANT FLORENCE L. BLUCHER 2703 HAMPDEN AVE	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE ASCVD DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). PROSTATISM WITH UTI				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH UNKNOWN			
19A. DATE OF OPERATION 10-26-72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED TUR-BPH		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 10-13-1972 to 12-8-1972 that (I) (we) lost saw the deceased alive on 12-8-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Roger L. Gordon MD				23B. DATE SIGNED 12-8-72			
23C. PHYSICIAN'S NAME (Type) ROGER L. GORDON MD				23D. ADDRESS c/o MARYLAND GENERAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-12-72		24C. NAME OF CEMETERY or CREMATORY St. Marys		24D. LOCATION (City, town, or county) (State) Hampden	
25A. DATE REC'D BY HEALTH DEPT. DEC 13 1972		25B. NAME OF REGISTRAR Paul E. Schumann		25C. FUNERAL DIRECTOR Paul E. Schumann		25D. ADDRESS 3615 Chestnut Ave	

100

100

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 11793	
CERTIFICATE OF DEATH				REG. NO. 72 11793	
STATE OF MARYLAND - DEPT. OF HEALTH				72 11793	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
CHRISTINA M. MULLIN		12/9/72		3 20 p.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
The Gould Convalesarium			Md. Balto.		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Rosedale		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
			E. STREET AND NUMBER		
			1830 Wilhelm Ave		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Jan 17 1913	59	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Packager		Distilling Co.		Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
John Borleis			Bertha Fick		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		217-26-1185		Gloria Wilhelm 1830 Wilhelm Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Embolic Stroke 18h		
			(B) Antisclerotic Embolic Stroke months.		
			(C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
Chronic Brain Spasm. Probable Abscess of Brain					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from 5/9/72 to 12/9/72 that (I) (we) last saw the deceased alive on 12/9/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
Albert B. Bradley			12/9/72		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
ALBERT B. BRADLEY			4900 BELAIR Rd. BALTO Md.		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		12/9/72		Baltimore Cemetery	
				Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
DEC 13 1972		Philip E. Grach		1211 Chesaco Ave	

ALBERT B. BRYANT AND HIS WIFE

1892

10000000

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 72 11794	
BIRTH NO. 72 11794				STATE OF MARYLAND - DEPT.	
1. NAME OF DECEASED (Type or Print) <u>Blitz-Mr. Jacob</u>			2. DATE AND HOUR OF DEATH <u>12/6/72</u> <u>4:10</u> <u>A</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Hamilton Nursing Center</u> <u>906040 Harbor Rd. #21214</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>BALTO</u> C. CITY OR TOWN <u>Dundalk</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>1943 1101 born Rd. 21222</u>		
5. SEX <u>M</u>	6. RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/5/184</u>	9. AGE (In years last birthday) <u>88</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired steel worker.</u>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>Unknown</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>not known</u>		16. SOCIAL SECURITY NO. <u>215-07-4695</u>	17. INFORMANT <u>Gail K. Armiger R.O.</u>		
18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>severe osteoarthritis</u>			CAUSE OF DEATH <u>MYOCARDIAL INFARCT, probable</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>SEVERE ASCUD</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>PARKINSON'S D.</u> (C) <u>within 1 hr</u> <u>30 YRS</u> <u>20 YRS</u>		
19A. DATE OF OPERATION <u>none</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) <u>no</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) <u>no</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) <u>none</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>11/6</u> 19 <u>72</u> to <u>12/6</u> 19 <u>72</u> , that (I) (we) last saw the deceased alive on <u>12/5</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>PACoyne MD</u>				23B. DATE SIGNED <u>12/6/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>PACoyne MD</u>				23D. ADDRESS <u>615 W 40th BALTD Md 21211</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/9/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Oak Lawn</u>	
24D. LOCATION (City, town, or county) <u>Baltimore, Maryland</u>		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 13 1972</u>		25B. NAME OF REGISTRAR <u>Sidney H. ...</u>		25C. FUNERAL DIRECTOR <u>John J. Duda</u>	
25D. ADDRESS <u>7922 Wise Ave. Balt. Md. 21222</u>					





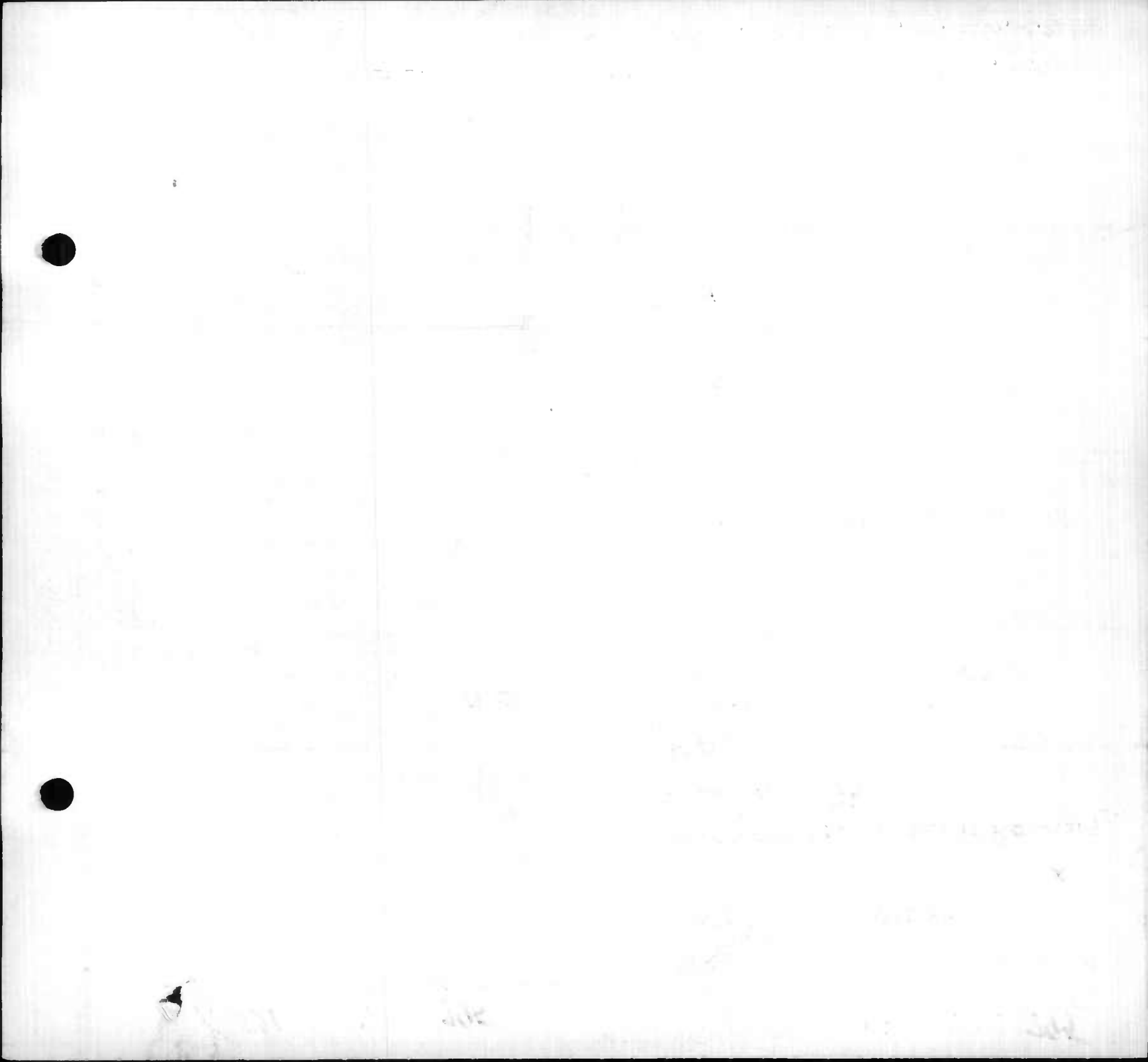
100

100

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

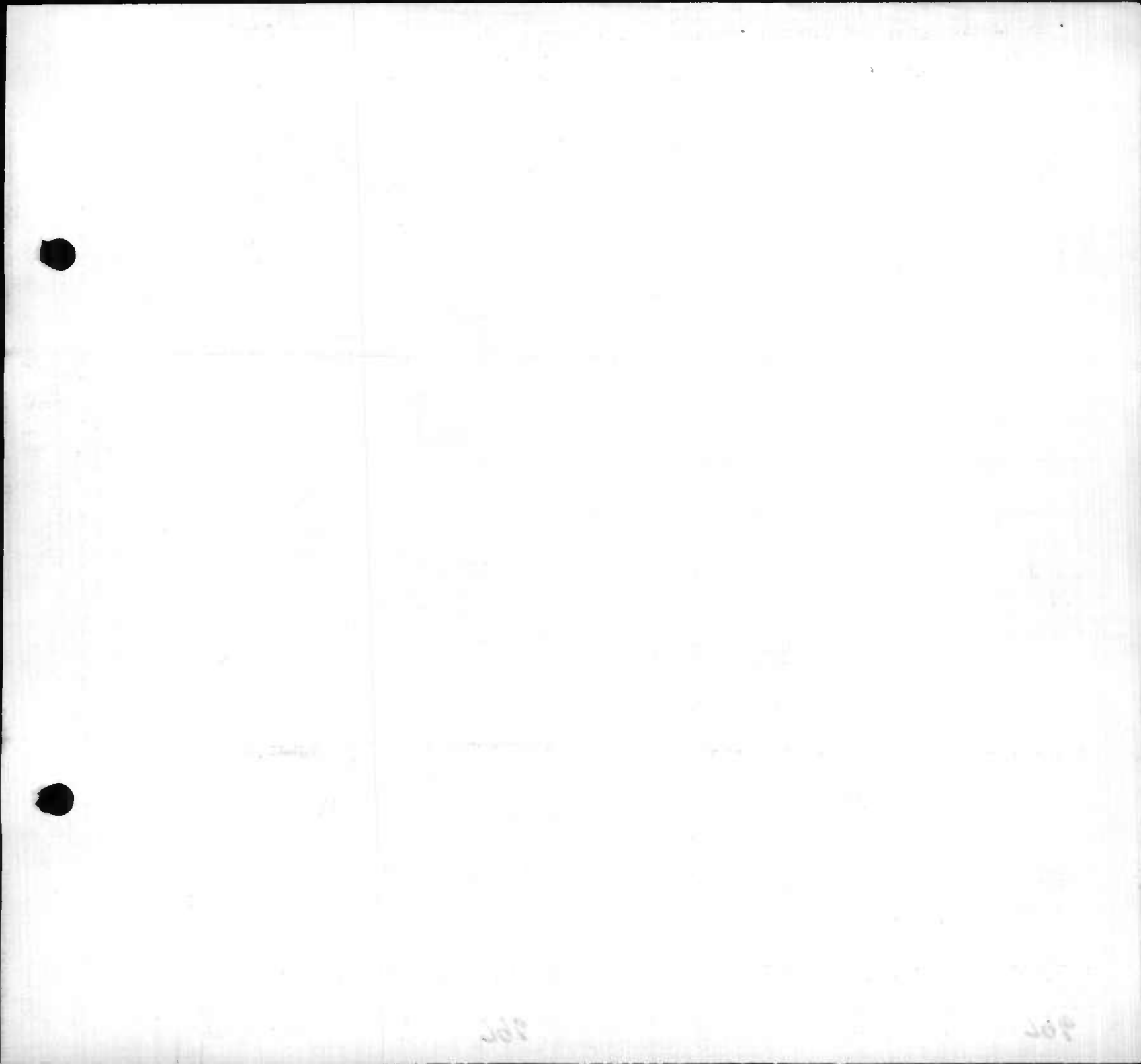
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 72 11795 STATE OF MARYLAND-DEMH	
BIRTH NO. K-521		72 11795			
1. NAME OF DECEASED (Type or Print) Elmer Kingsborough KINGS BOROUGH, MR. ELMER.		2. DATE AND HOUR OF DEATH 12/8/72		12-20 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) CHURCH HOME & HOSPITAL 100 N BROADWAY. BALTIMORE. MD. 21232		A. STATE Maryland B. COUNTY Baltimore		5300	
		C. CITY OR TOWN BALTIMORE 21219		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER 6500 OLD NORTH POINT RD. 21219			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-26-95	9. AGE (In years last birthday) 77	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED ?		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) PA.	
13. FATHER'S NAME OREN KINGS BOROUGH		14. MOTHER'S MAIDEN NAME ? Carrie		12. CITIZEN OF WHAT COUNTRY? AMER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 216 105056		17. INFORMANT DOROTHY M. KINGSBOROUGH, 6500 Old N. Pt.	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAADIO pulmonary arrest. R/o Aspiration		15 mts.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: 18000 pneumonia			
		(B) Possible Ca bowel		Months.	
		(C) Chronic brain syndrome			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 12/3/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notably medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/6/1972 to 12/8/1972 that (I) (we) lost saw the deceased alive on 12/8/1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE L. Padmaraju, M.D.		23B. DATE SIGNED 12/8/72			
23C. PHYSICIAN'S NAME (Type) L. PADMARAJU, M.D.		23D. ADDRESS CHURCH HOME & HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-11-72		24C. NAME OF CEMETERY or CREMATORY Gardens of Faith	
24D. LOCATION Baltimore		Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. DEC 13 1972		25B. NAME OF REGISTRAR Sidney H. Gordon		25C. FUNERAL DIRECTOR John J. Duda 7922 Wise Ave. Balto, Md. 21222	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT			
CERTIFICATE OF DEATH			
BIRTH NO. <b>11-255</b>		REG. NO. <b>72 11796</b>	
1. NAME OF DECEASED (Type or Print) <b>MESSMAN, MARGARET, M.</b>		2. DATE AND HOUR OF DEATH <b>DEC. 9, 1972</b> <b>430 P. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>CHURCH HOME AND HOSPITAL</b> <b>35</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>619 MACE AVE.</b>	
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-27-26</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waitress</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>	9. AGE (In years last birthday) <b>46</b>
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>AMERICA</b>	
13. FATHER'S NAME <b>HARRY A. LEVY</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET GOLDBECK</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-22 1957</b>	
17. INFORMANT <b>Shurl Messman</b>		ADDRESS <b>Same</b>	
18. <b>162.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CARCINOMA OF LUNG</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 MOS.</b>	
19A. DATE OF OPERATION <b>11-14-72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CARCINOMA OF LUNG</b>	
20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Nov. 13</b> 19 <b>72</b> to <b>Dec. 9</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>Dec. 9</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Adolfo G. Torres MD</b>		23B. DATE SIGNED <b>Dec 9 72</b>	
23C. PHYSICIAN'S NAME (Type) <b>ADOLFO G. TORRES</b>		23D. ADDRESS <b>410 CHURCH HOME HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/12/72</b>	
24C. NAME of CEMETERY or CREMATORY <b>Gardens of Faith Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland 21237</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 13 1972</b>		25B. NAME OF REGISTRAR <b>James E. Bruzdinski</b>	
25C. FUNERAL DIRECTOR <b>James E. Bruzdinski</b>		ADDRESS <b>1407 Eastern Ave.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				CERTIFICATE OF DEATH		STATE OF MARYLAND - DEPT. OF HEALTH	
7-652		72 11 797		12 11 797			
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) <b>FRANKE, LUCY A</b>				2. DATE AND HOUR OF DEATH <b>12-10-72 1:35 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>M.D.</b> B. COUNTY <b>2735</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>44 THE UNION MEMORIAL HOSP.</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTO</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>4700 HARFORD ROAD</b>		<b>HARFORD CONVI.</b>	
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-20-85</b>	9. AGE (In years last birthday) <b>87</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>M.D.</b>		12. CITIZEN OF WHAT COUNTRY? <b>AMERICAN</b>	
13. FATHER'S NAME <b>George Insly</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Howard</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-10-1651</b>		17. INFORMANT <b>Robert Bloodsworth Sr</b>		ADDRESS <b>8 Main St Jacobus, Pa</b>	
18. <b>486X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>about 11 days</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>6</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>11-29</b> 19 <b>72</b> to <b>12-10</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>12-10</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Jadastri Kuba</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>12-10-72</b>	
23C. PHYSICIAN'S NAME (Type) <b>THE UNION MEMORIAL HOSPITAL</b>				23D. ADDRESS <b>33rd and Calvert St. BALTO, M.D.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/13/72</b>		24C. NAME of CEMETERY or CREMATORY <b>Parkwood</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 13 1972</b>		25B. NAME OF REGISTRAR <b>Leonard J. Ruck Inc.</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc.</b>		ADDRESS <b>Baltimore, Md</b>	

7/5/68 - Adm.  
3009 Northway Dr.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 72 11798 STATE OF MARYLAND, DEPT.	
BIRTH NO. B-650		72 11798			
1. NAME OF DECEASED (Type or Print) <b>NORMA Norma S. Brown</b>			2. DATE AND HOUR OF DEATH <b>12-10-72 8-10 PM</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Lutheran Hospital of Maryland</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>904</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>503 E. 24th St.</b> <b>21218</b>		
5. SEX <b>Female</b>	6. RACE <b>XXI Cauc.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-23-06</b>		9. AGE (In years last birthday) <b>65</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>George A Frick</b>			14. MOTHER'S MAIDEN NAME <b>Anne McGee</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>217-18-1756</b>		17. INFORMANT <b>Mr Chester T Brown</b> ADDRESS <b>Same</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Acute fibrous pericarditis 72 days</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>chronic bilateral pneumonia 50 days</b> (C) <b>—</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Rheumatic Heart Disease</b>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indefinite medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from <b>12-5-1972</b> to <b>12-10-1972</b> that (X) (we) lost saw the deceased alive on <b>12-10-1972</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Ches T Brown MD</b>			23B. DATE SIGNED <b>12-10-72</b>		
23C. PHYSICIAN'S NAME (Type) <b>M. A. A. N. N. N. MD</b>			23D. ADDRESS <b>Lutheran Hospital of Maryland</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/13/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Gardens Of Faith</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 13 1972</b>			
25B. NAME OF REGISTRAR <b>Sidney H. Brown</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Buck Inc. Balto. Md. 21214</b>			

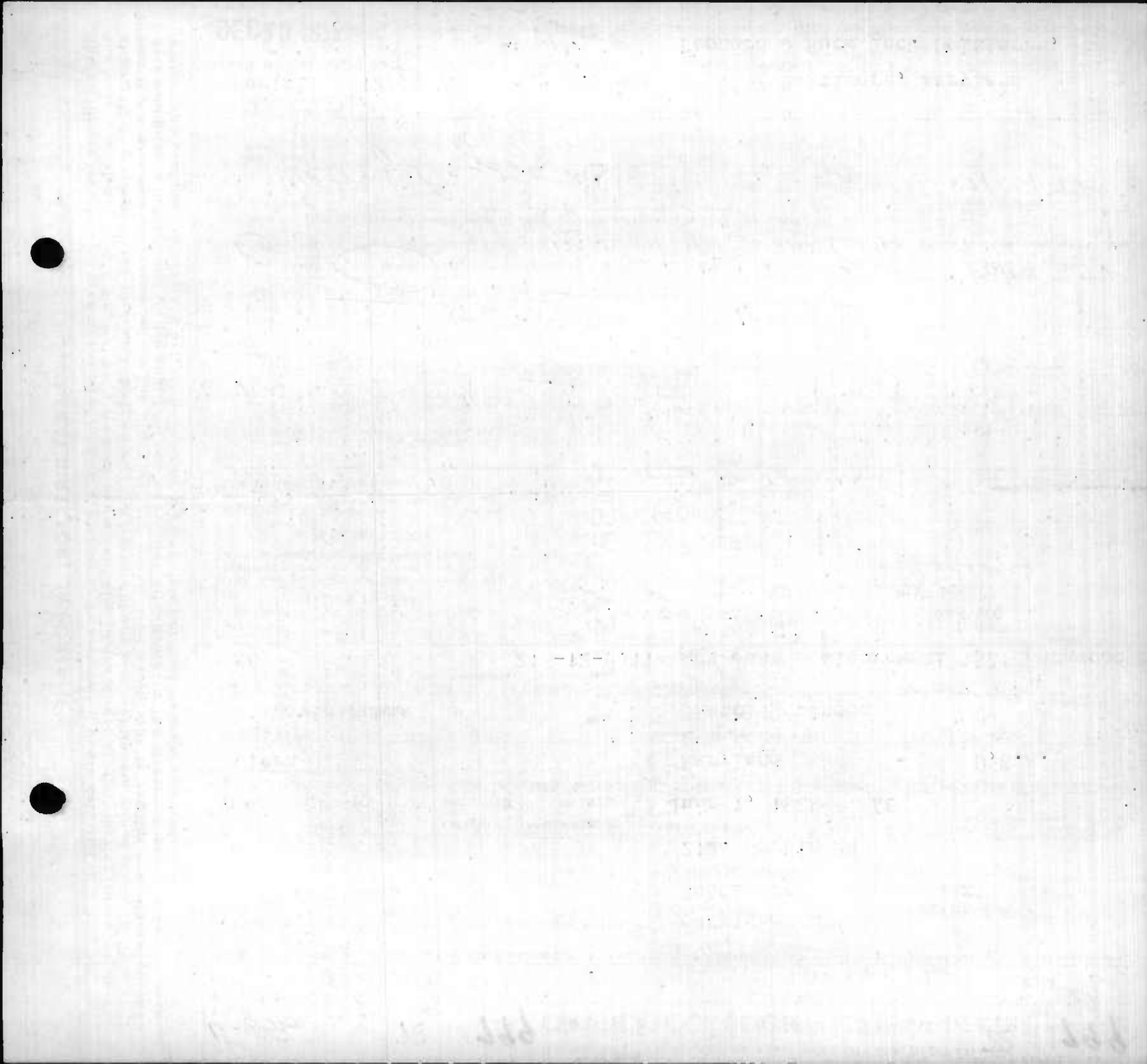
Joc

48

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
72 11799 CERTIFICATE OF DEATH											
72 11799											
BIRTH NO. 4-256											
1. NAME OF DECEASED (Type or Print) <b>HAGNER, HAZEL</b>						2. DATE AND HOUR OF DEATH <b>12-10-72 4 P.M.</b>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION <b>37 Mercy</b>						A. STATE <b>Maryland</b>					
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)						C. CITY OR TOWN <b>Baltimore</b>			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
						E. STREET AND NUMBER <b>2124 Corbin Rd</b>					
5. SEX <b>FEMALE</b>		6. RACE <b>CAUCASIAN</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 1, 1924</b>		9. AGE (In years last birthday) <b>48</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>David Mumma</b>						14. MOTHER'S MAIDEN NAME <b>Hazel Robinson</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>218-12-6311</b>		17. INFORMANT <b>Mrs June M Klebrowski 1521 Burnwood</b>					
18. <b>174X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of breast, metastatic to bone with hypercalcemia</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).											
19A. DATE OF OPERATION <b>None</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>no</b>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>11/21 1972</b> to <b>12/10 1972</b> , that (I) (we) last saw the deceased alive on <b>12/10 1972</b> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <b>Victor J Rogosa M.D.</b>						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>12/10/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>VICTOR J. ROGOSA</b>						23D. ADDRESS <b>Leonard J. Ruck Inc. Baltimore, Md</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>12/14/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 13 1972</b>				25B. NAME OF REGISTRAR <b>Sidney Johnston</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. Baltimore, Md</b>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span>R-612</span> <span>72 11800</span> <span>CERTIFICATE OF DEATH</span> </div>		REG. NO. <span style="float: right;">72 11800</span>	
BIRTH NO. <span style="float: right;">STATE OF MARYLAND-DEME</span>		2. DATE AND HOUR OF DEATH <span style="float: right;">December 7, 1972 9:45 A.M.</span>	
1. NAME OF DECEASED (Type or Print) <span style="float: right;">1348</span>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="float: right;">Maryland</span> B. COUNTY <span style="float: right;">Baltimore</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 2em; float: left; margin-right: 10px;">42</span> <span style="font-size: 2em; float: left; margin-right: 10px;">99</span> <span style="float: right;">Sinai Hospital (DOA)</span>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <span style="float: right;">M</span>	6. RACE <span style="float: right;">W</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="float: right;">Sept. 16, 1913</span>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <span style="float: right;">59</span>
Painter 11. BIRTHPLACE (State or foreign country) <span style="float: right;">Maryland</span>		12. CITIZEN OF WHAT COUNTRY? <span style="float: right;">U S A</span>	
13. FATHER'S NAME <span style="float: right;">Arthur Rohrback</span>		14. MOTHER'S MAIDEN NAME <span style="float: right;">Mary</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <span style="float: right;">219 01 0450</span>	17. INFORMANT <span style="float: right;">Ruth Rohrback</span>
No		ADDRESS <span style="float: right;">Same</span>	
18. <span style="font-size: 2em; float: left; margin-right: 10px;">410.9</span> I		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  (A) IMMEDIATE CAUSE <span style="font-size: 1.5em;">Acute myocardial infarction Immediate</span> DUE TO, OR AS A CONSEQUENCE OF:  (B) <span style="font-size: 1.5em;">Arteriosclerotic cardiovascular disease 10 years</span> DUE TO, OR AS A CONSEQUENCE OF:  (C)	
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		<span style="font-size: 1.5em;">1) Hypertension 2) Hyperuricemia</span>	
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <span style="float: right;">No</span>	20B. IN YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.5em;">March</span> 1972 to <span style="font-size: 1.5em;">December</span> 1972, that (I) (we) last saw the deceased alive on <span style="font-size: 1.5em;">December 6</span> 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.			
23A. SIGNATURE <span style="font-size: 1.5em;">Henry J. Balitt, M.D.</span>		23B. DATE SIGNED <span style="font-size: 1.5em;">December 9, 1972</span>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <span style="font-size: 1.5em;">4623 Hawksbury Rd Balt, Md</span>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <span style="font-size: 1.5em;">11 Dec. 72</span>	24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.5em;">Lorraine Park Cemetery</span>
Burial		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.5em;">DEC 13 1972</span>	25B. NAME OF REGISTRAR <span style="font-size: 1.5em;">Sidney Johnston</span>	25C. FUNERAL DIRECTOR <span style="font-size: 1.5em;">Burgee Funeral Home</span> ADDRESS <span style="font-size: 1.5em;">Balto., Md.</span>	

Handwritten text, possibly a signature or date, appearing as "Jan 2 1880".

Handwritten text, possibly a date or reference number, appearing as "1880".

Handwritten text, possibly a date or reference number, appearing as "1880".

Handwritten text, possibly a date or reference number, appearing as "1880".

Handwritten text, possibly a date or reference number, appearing as "1880".

Handwritten text, possibly a date or reference number, appearing as "1880".

Handwritten text, possibly a date or reference number, appearing as "1880".

Handwritten text, possibly a date or reference number, appearing as "1880".

Handwritten text, possibly a date or reference number, appearing as "1880".

Handwritten text, possibly a date or reference number, appearing as "1880".

Handwritten text, possibly a date or reference number, appearing as "1880".

Handwritten text, possibly a date or reference number, appearing as "1880".

Handwritten text, possibly a date or reference number, appearing as "1880".

Handwritten text, possibly a date or reference number, appearing as "1880".

Handwritten text, possibly a date or reference number, appearing as "1880".

Handwritten text, possibly a date or reference number, appearing as "1880".

Handwritten text, possibly a date or reference number, appearing as "1880".

Handwritten text, possibly a date or reference number, appearing as "1880".

Handwritten text, possibly a date or reference number, appearing as "1880".

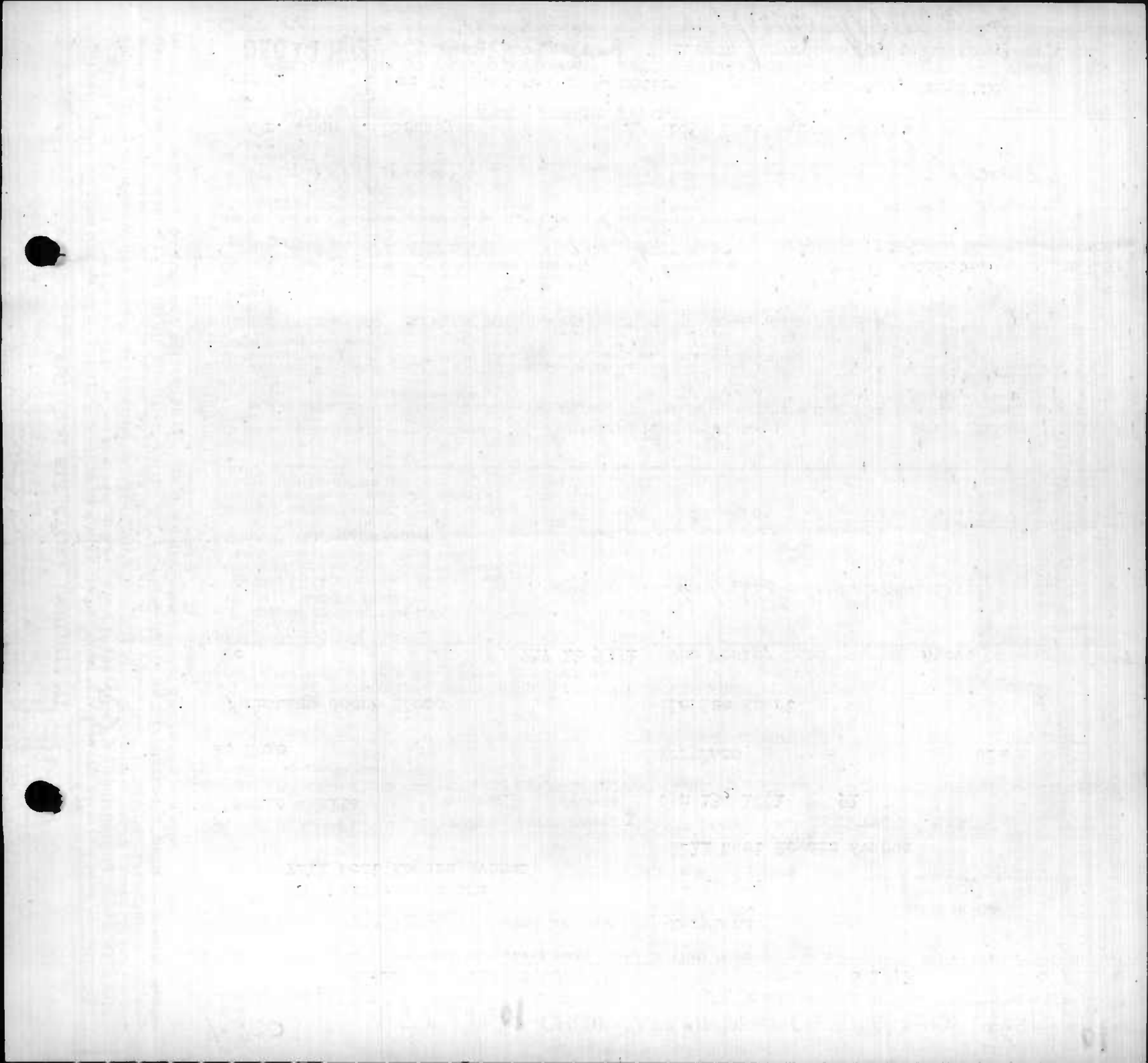


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.2em;">72 11801</span>
Y-200		72 11801		STATE OF MARYLAND - DHH
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH
		BLANCHE LOUISE YOUSE		December 6 1972 <span style="float: right;">4 P M.</span>
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		B. COUNTY		
90 The Wesley Home Inc		Maryland		
2211 West Rogers Avenue		C. CITY OR TOWN		D. INSIDE CITY LIMITS?
		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER		
		2211 West Rogers Avenue		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Jan 13, 1881	91
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
At Home				Maryland
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?
Christian Jacob Youse		Louise Ebert		USA
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT
No		217 12 5331		The Wesley Home
				Above
18. <span style="font-size: 1.2em;">472.4</span>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)		<i>Arteriosclerotic cardio-vascular disease</i>		
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) _____		
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
				No
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
22. I certify that (I) (this hospital) attended the deceased from <i>January</i> 19 <i>66</i> to <i>6 December</i> 19 <i>72</i> , that (I) (we) last saw the deceased alive on <i>30 November</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
23A. SIGNATURE		23B. DATE SIGNED		
<i>John W. Barnaby</i>		8 Dec 72		
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
Dr. John W. Barnaby		1652 East Belvedere Ave		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY
Burial		8 Dec 72		Loudon Park Cemetery
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR
DEC 13 1972		<i>Sidney H. Hinton</i>		Burgess Funeral Home, Baltimore, Maryland
				By: <i>Wanda M. B. B. Jr.</i>





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 11802		72 11802	
BIRTH NO.				H-600		72 11802	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Orpha c. Hare				Dec. 7, 1972   10 45 p.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
Sinai Hospital of Baltimore				Md. 1348			
5. SEX F				6. RACE Cau		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
Floor Lady				Clothing Mfr		2-6-85	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME		9. AGE (in years last birthday) 87	
Ann Allen J. Eccard				Amanda M Shoreyer		11. BIRTHPLACE (State or foreign country) U.S.A. Maryland	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				216 o7 1252		Hazel M Hanson 4202 Elsa Terrace	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				Cerebro Vascular Accident			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				C			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from Nov. 30 1972 to Dec. 7 1972		that (I) (we) last saw the deceased alive on Dec. 7 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
Santos Uy, Jr., M.D.				Dec. 7, 1972		Santos A. Uy, Jr. MD	
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial				11 Dec 72		Mt. Olivet Cem	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
DEC 13 1972				Sandy Johnson		Lungee Funeral Home, Baltimore Md	

11/19/71 - Adm.

4202 E/5a Terrace.

21211

72 11803

STATE OF MARYLAND-DHMH  
BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 11803

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Melvin English

2. DATE  
OF DEATHKnown ☒ Estimated ☐Month  
12Day  
9Year  
72Hour  
11:20 A.M.4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

1433 W. Baltimore Co.

3. DATE  
PRONOUNCED DEADMonth  
12Day  
9Year  
72Hour  
11:20 A.M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE  
Maryland

B. COUNTY

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

9/30/72

10. AGE (in years  
last birthday)

25

11. Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

547 Dolphin Street

11. BIRTHPLACE (State or foreign country)

Baltimore, Md

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James English

14. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Unemployed

148. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Ola Mae Fisher

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

Mrs Ola Mae English same

19.

304.91

CAUSE OF DEATH

Narcotics addiction and acute ethylism

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (if in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

William P. Mulloy, M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED  
12-10-7224A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

12/15/72

24C. NAME of CEMETERY or CREMATORY

MT Auburn Cemetery

24D. LOCATION (City, town, or county)

Baltimore Md

(State)

25A. DATE REC'D BY HEALTH DEPT

DEC 19 1972

25B. NAME OF REGISTRAR

Sidney H. [Signature]

25C. FUNERAL DIRECTOR

ADDRESS

Adolphus Halstead 1206 W North Md

1-19-1973 - Completion of cause of death on a pending medical examiner death certificate-  
William P. Mulloy, M.D., Assistant Medical Examiner hs

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 11804

BIRTH NC.

1. NAME OF DECEASED (Type or Print) <b>CARTER SANDERS</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>911 N. Carrollton Avenue</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>December 2, 1972 7:25 A.M.</b>	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1601</b>			
6. SEX <b>Male</b>	7. RACE <b>Negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>1920</b>		10. AGE (In years, months, days, hours, minutes) <b>52</b>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME		14. STREET AND NUMBER <b>911 N. Carrollton Avenue</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>Mr Robert Lyles, Same</b>		ADDRESS	
19. I <b>371.8</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH <b>Lobar pneumonia</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) <b>Fatty metamorphosis of liver</b> DUE TO, OR AS A CONSEQUENCE OF:  (C) _____	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>12/2/72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/12/72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt Auburn Cemetry</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md</b>	
25A. DATE REC'D BY HEALTH DEPT <b>DEC 13 1972</b>		25B. NAME OF REGISTRAR <b>Adolphus Halstead</b>	
25C. FUNERAL DIRECTOR <b>Adolphus Halstead</b>		ADDRESS <b>1206 W North Ave</b>	

ACQUAINTANCE

100

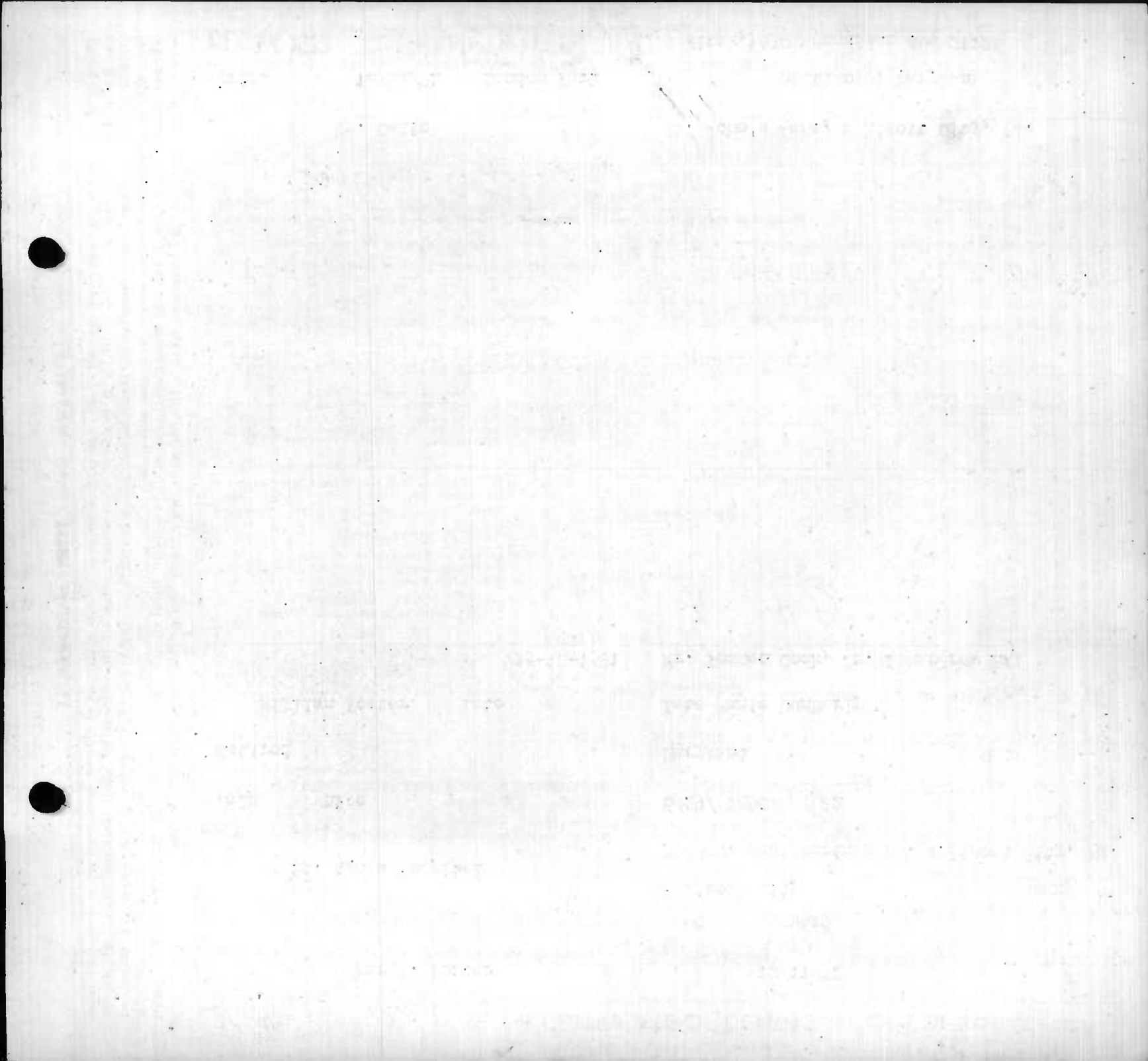
200



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 11805		72 11805	
CERTIFICATE OF DEATH				REG. NO. 72 11805		STATE OF MARYLAND - DEMO	
BIRTH NO. <b>7-236</b>		72 11805		2. DATE AND HOUR OF DEATH <b>12/11/72</b>		M.	
1. NAME OF DECEASED (Type or Print) <b>Edgar F. Foster</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md</b> B. COUNTY <b>Howard</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>40 St. Agnes Hospital</b>				C. CITY OR TOWN <b>Ellicott City</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>Male</b>				6. RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>6/29/1890</b>		9. AGE (In years last birthday) <b>82</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>William Foster Late</b>		14. MOTHER'S MAIDEN NAME <b>Late Annie Dunkerly</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Retired</b>	
16. SOCIAL SECURITY NO. <b>215-10-1591</b>		17. INFORMANT <b>Mr. Thomas Cook, Jr. 2 Mardrew Rd</b>		ADDRESS			
18. CAUSE OF DEATH <b>412.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>0</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>A. S. H. D.</b>			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>1969</b> to <b>12-11-1972</b> , that (I) (we) last saw the deceased alive on <b>9-25-1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Barbara Coleen</b>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>12-12-72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Calin</b>				23D. ADDRESS <b>St. John's Lane, Ellicott City, Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/14/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 14 1972</b>		25B. NAME OF REGISTRAR <b>Anthony J. [Signature]</b>		25C. FUNERAL DIRECTOR <b>Witzke, 1630 Edmondson Ave 21228</b>		ADDRESS	



BIRTH NO.

72 11806

STATE OF MARYLAND-DHMH  
BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 11806

1. NAME OF DECEASED (Type or Print) <b>FREDERICK A. HARTUNG</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 12 Day 10 Year 1972 Hour 1:20p M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>309 S. Augusta Ave.</b>		3. DATE PRONOUNCED DEAD Month 12 Day 10 Year 1972 Hour 1:20 P M.	
6. SEX <b>male</b>		7. RACE <b>white</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2008</b>	
9. DATE OF BIRTH <b>1/8/12</b>		10. AGE (In years last birthday) <b>60</b> If Under 1 Yr. if Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Late-Henry Hartung</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Elec. Consult. Eng.</b>	
15. MOTHER'S MAIDEN NAME <b>Vernie Arnold Hartung</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>	
17. SOCIAL SECURITY NO. <b>579-05-0318</b>		18. INFORMANT <b>Sullivans Trailer Address Maryland</b> <b>Mrs. Meda K. Hartung, Rte #1 Lot 18 Finksburg,</b>	
19. <b>412.4</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Marvin S. Platt</b> M.D. EXAMINER'S NAME (Type) <b>Marvin S. Platt, M.D.</b> DATE SIGNED <b>12-11-72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/14/72</b>	
24C. NAME of CEMETERY or CREMATORY <b>Pleasant View Church/Brethren</b>		24D. LOCATION (City, town, or county) (State) <b>Burkittsville, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 14 1972</b>		25B. NAME OF REGISTRAR <b>Sidney Witzke</b>	
25C. FUNERAL DIRECTOR <b>Witzke, 1630 Edmondson Avenue, 21228</b>		ADDRESS	

10075

10075

Y. 10075

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
72 11807 CERTIFICATE OF DEATH									
REG. NO. 72 11807									
1. NAME OF DECEASED (Type or Print) <b>ETHEL R. MELLOR</b>					2. DATE AND HOUR OF DEATH <b>12/12/72 9:20p</b>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>2854</b>				
FULL NAME OF HOSPITAL OR INSTITUTION		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
<b>8 Maryland General Hospital</b>					E. STREET AND NUMBER <b>121 Mallow Hill Rd</b>				
5. SEX <b>7</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/01/90</b>		9. AGE (In years last birthday) <b>82</b>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SEAMSTRESS</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>CATONSVILLE Md</b>		12. CITIZEN OF WHAT COUNTRY <b>US</b>	
13. FATHER'S NAME <b>ALBERT L. MELLOR</b>					14. MOTHER'S MAIDEN NAME <b>LAURA M. HOGAN</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>214-16-5263</b>		17. INFORMANT <b>EMMA J. MELLOR</b>		ADDRESS <b>SAME</b>	
18. <b>571.9 I</b> CAUSE OF DEATH									
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)					(A) IMMEDIATE CAUSE <b>Hepatic Coma</b> DUE TO, OR AS A CONSEQUENCE OF:				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) <b>Cirrhosis of Liver &amp; ascites</b> DUE TO, OR AS A CONSEQUENCE OF:				
					(C) _____				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <b>0</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>11/21</b> 19 <b>72</b> to <b>12/12</b> 19 <b>72</b> that (I) (we) lost saw the deceased alive on <b>12/12</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Robert B. Grossman M.D.</b>						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>12/12/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>ROBERT B. GROSSMAN MD</b>						23D. ADDRESS <b>MD. GEN'L. HOSP.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			24B. DATE <b>12/16/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>St. John's Cemetery</b>		24D. LOCATION <b>Ellicott City, Md.</b>		(State)
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 14 1972</b>			25B. NAME OF REGISTRAR <b>Sidney Witzke</b>			25C. FUNERAL DIRECTOR <b>Witzke Catonsville Funeral Home</b>			
ADDRESS <b>1630 Edmondson Avenue 21228</b>									

11 211

11 211

11 211

11 211

11 211

11 211

11 211

11 211

11 211

11 211

11 211

11 211

11 211

11 211

11 211

11 211

11 211



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 11808</u>	
W-536				72 11808	
BIRTH NO.				STATE OF MARYLAND DEPT	
1. NAME OF DECEASED (Type or Print) <b>Mrs. Mildred Elizabeth Winters</b>		2. DATE AND HOUR OF DEATH <b>Dec. 12, 1972</b>		9:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Jenkins Memorial Hospital</b> <b>1000 Caton Avenue</b> <b>Baltimore, Md. 21229</b>		A. STATE <b>Md.</b>		B. COUNTY <b>City</b>	
C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <b>Jenkins Memorial, 1000 Caton Avenue</b>					
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 6, 1902</b>	9. AGE (In years last birthday) <b>70</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sales</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Dept. Store</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>James J. Glenn</b>		14. MOTHER'S MAIDEN NAME <b>Blanch E. Ballard</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-28-9475</b>		17. INFORMANT <b>Jenkins Memorial 1000 Caton Ave., 21229</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>7/12/3 I</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Coma</b> DUE TO, OR AS A CONSEQUENCE OF: <b>infected ulcers (multiple)</b> (B) TOXICITY FROM NARCOTIC AND DUE TO, OR AS A CONSEQUENCE OF: <b>Rheumatoid arthritis</b> (C) <b>years</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>3 wks</b> <b>years</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>he</del> (this hospital) attended the deceased from <b>3/9</b> 19 <b>72</b> to <b>12/12</b> 19 <b>72</b> . that (I) <del>we</del> lost saw the deceased alive on <b>12/12</b> 19 <b>72</b> and that in (my) <del>our</del> opinion death occurred on the date and hour and from the causes stated above. <del>He</del> (We) (did) <del>did not</del> view the body after death.					
23A. SIGNATURE <b>J. Raymond Gladue</b>		23B. DATE SIGNED <b>12/12/72</b>			
23C. PHYSICIAN'S NAME (Type) <b>J. Raymond Gladue</b>		23D. ADDRESS <b>Jenkins Memorial Hosp</b> <b>1000 Caton Ave</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/15/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Druid Ridge Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 14 1972</b>		25B. NAME OF REGISTRAR <b>Lillian Winters</b>		25C. FUNERAL DIRECTOR <b>Witzke, 1630 Edmondson Ave., 21228</b>	



3/9/72 - Adm.

709 Dryden Dr. 2/229

CT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 11809</u>	
72 11809				STATE OF MARYLAND - DHMH	
BIRTH NO. <u>S-351</u>		1. NAME OF DECEASED (Type or Print) <u>Stumpf, Gilbert Jesse</u>		2. DATE AND HOUR OF DEATH <u>12-11-72 - 9:10 pm</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Balto City, Maryland</u> B. COUNTY <u>401</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>49 N. Charles General Hospital</u> <u>2724 N Charles St. 21218</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Balto City (21201)</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>Male</u>		6. RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>carpenter</u>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <u>03/04/15</u> 9. AGE (In years last birthday) <u>57</u> 11. BIRTHPLACE (State or foreign country) <u>Cumberland, Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>yes(USA)</u>	
13. FATHER'S NAME <u>Calvin Stumpf (D)</u>		14. MOTHER'S MAIDEN NAME <u>Nora Myers (D)</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215 18 8167</u>		17. INFORMANT <u>pt's chart</u> ADDRESS <u>N. Charles General H. sp</u> <u>2724 N. Charles St. 21218</u>	
18. <u>151.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>CACCHEXIA</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Metastatic Ca</u> <u>Ca of Stomach</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CACCHEXIA</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Metastatic Ca</u> (C) <u>Ca of Stomach</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>12-7-72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Ca of Stomach</u>		20A. AUTOPSY? (Yes or No) <input type="checkbox"/> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12-2</u> 19 <u>72</u> to <u>12-11</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>12-11</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. <u>9:10 pm</u>					
23A. SIGNATURE <u>Edwards C. Yates M.D.</u>		Attending <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>12-11-72</u>	
23C. PHYSICIAN'S NAME (Type) <u>EDUARDO C. YATCO</u>		M.D. <u>NORTH CH</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/14/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Lorraine Park Cemetery</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		24E. DATE REC'D BY HEALTH DEPT. <u>DEC 14 1972</u>		24F. NAME OF REGISTRAR <u>Adrian Whorton</u>	
24G. FUNERAL DIRECTOR <u>Witzke, 1630 Edmondson Avenue 21228</u>		24H. ADDRESS			

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

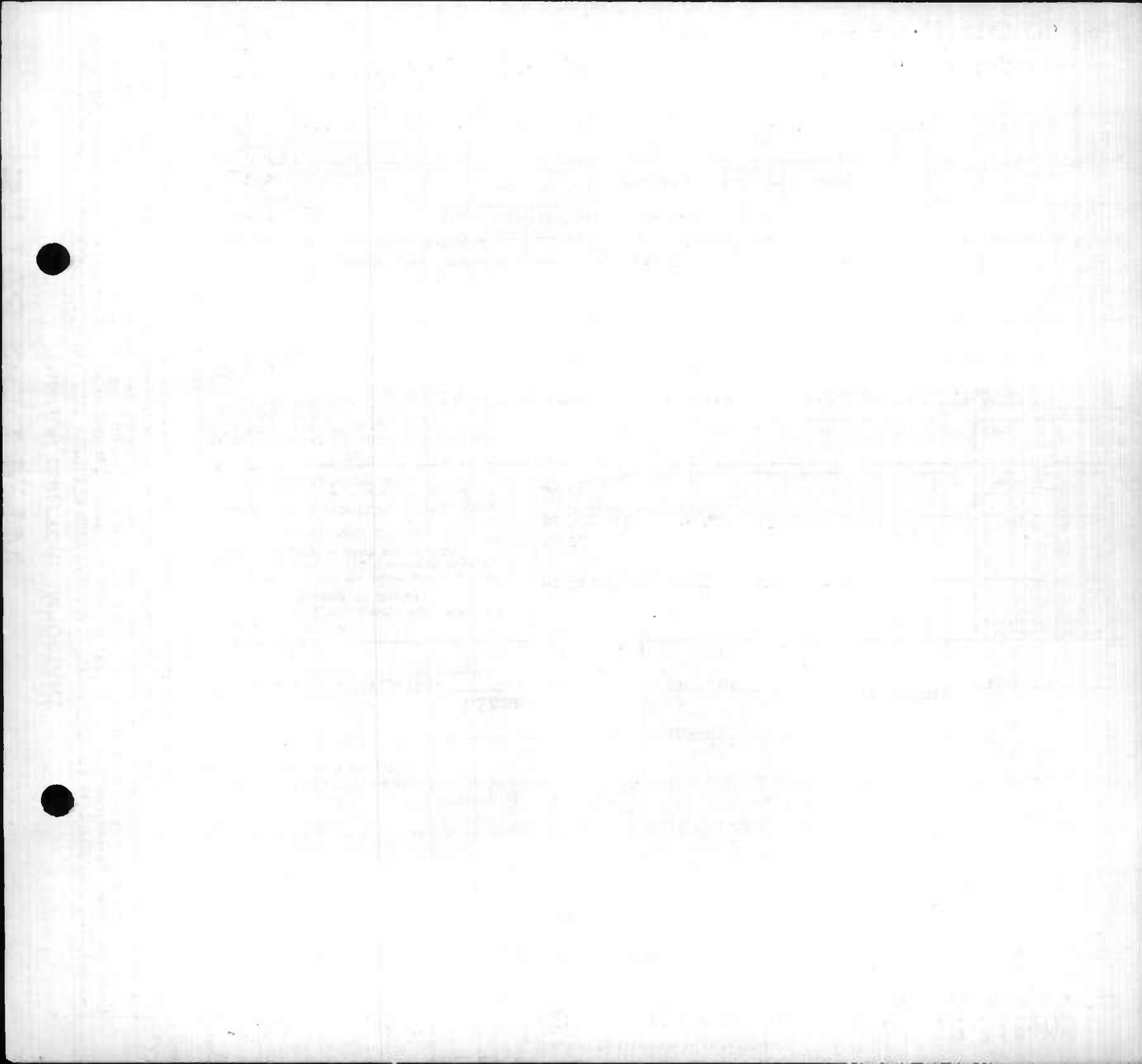
1914

1914

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 11810	
72 11810				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Otto Hugo Lissau</u>		2. DATE AND HOUR OF DEATH <u>December 11-1972</u> <u>4:00 A</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Maryland General Hospital</u> <u>48</u>		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2733</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>4805 Pilgrim Rd</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-23-89</u>		9. AGE in years last birthday <u>83</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baker</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	
13. FATHER'S NAME <u>Lissau</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-30-8804</u>		17. INFORMANT <u>Daughter</u> ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>PULMONARY CONGESTION</u> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Chronic Obstructive Pulmonary</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Asphyxiation</u> (B) <u>Chronic Obstructive Pulmonary</u> DUE TO, OR AS A CONSEQUENCE OF: <u>ASCVD - Possible Myocardial Infarct</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Chronic Obstructive Pulmonary</u>					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12-4</u> 19 <u>72</u> to <u>12/11</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>12/11/72</u> 19 <u>72</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Brian J. Winter MD</u>		23B. DATE SIGNED <u>12/11/72</u>		23C. PHYSICIAN'S NAME (Type) <u>BRIAN J. WINTER MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/14/72</u>		24C. NAME of CEMETERY or CREMATORY <u>Holy Redeemer</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 14 1972</u>		25B. NAME OF REGISTRAR <u>Sidney H. Korman</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc. Baltimore, Md</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-655 72 11811		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 11811	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>GEORGE A. BRANHAM</b>		2. DATE AND HOUR OF DEATH <b>December 9, 1972 9:20 p.m.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>BALTIMORE</b>		5. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
FULL NAME OF HOSPITAL OR (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>SOUTH BALTIMORE GENERAL HOSPITAL</b>		E. STREET AND NUMBER <b>4400 FAIRHAVEN AVENUE</b>					
5. SEX <b>MALE</b>	6. RACE <b>B WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/9/17</b>	9. AGE (in years last birthday) <b>55</b>	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ABRAHAM BRANHAM</b>		14. MOTHER'S MAIDEN NAME <b>WILLIAMNN WILLIS</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <b>No</b>		16. SOCIAL SECURITY NO. <b>215 05 7741</b>		17. INFORMANT <b>George A. Branham</b> ADDRESS <b>RT. 5 Box 486 Dogwood Rd.</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>410.91 + 291.0</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Myocardial infarction</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Coronary Artery disease</b>		<b>Unknown</b>			
(C) _____							
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Alcoholism and Delirium tremens</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Dec. 8</b> 19 <b>72</b> to <b>Dec. 9</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>Dec. 9</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Roberto C. Feliciano</b>		23B. DATE SIGNED <b>12/9/72</b>					
23C. PHYSICIAN'S NAME (Type) <b>ROBERTO C. FELICIANO</b>		23D. ADDRESS <b>South Baltimore General Hospital 3001 - South Hammer St., Baltimore MD</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>12-13-72</b>	24C. NAME OF CEMETERY OR CREMATORY <b>GLEN BURNIE CEM</b>		24D. LOCATION (City, town, or county) (State) <b>GLEN BURNIE MARYLAND</b>			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <b>Sally...</b>		25C. FUNERAL DIRECTOR <b>HARRIS FUNERAL HOME 4200 PENNINGTON AVE.</b>			

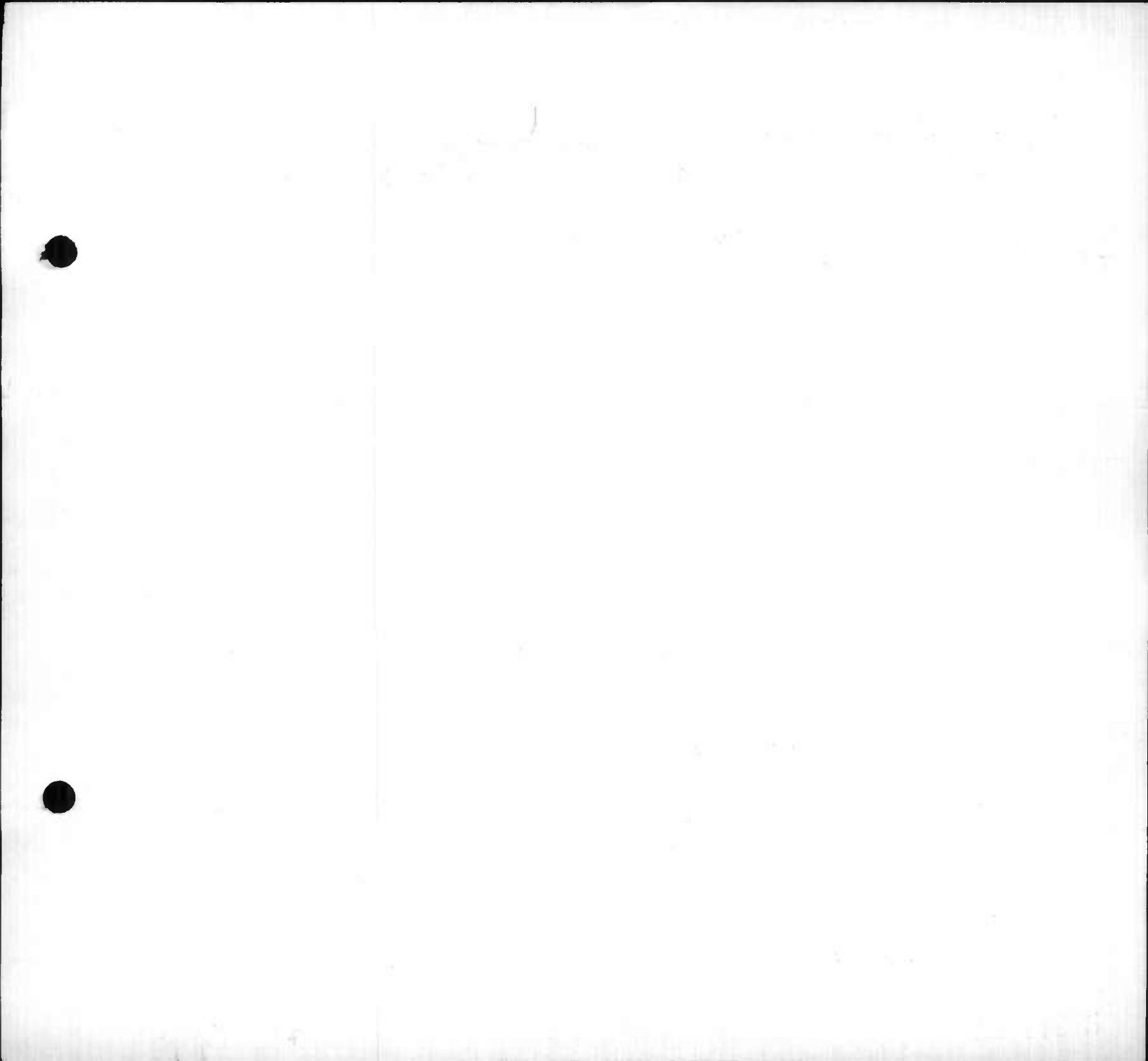




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-612		72 11812		BALTIMORE CITY HEALTH DEPARTMENT		72 11812	
BIRTH NO.		72 11812		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <u>ANNA T. GARPSTAS</u>				2. DATE AND HOUR OF DEATH <u>12-9-72</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> 8. COUNTY <u>2505</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>00</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>4314 Curtis Ave.</u> <u>Baltimore, Maryland 21226</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>Female</u>		6. RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 7, 1885</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		9. AGE (in years last birthday) <u>87</u>		11. BIRTHPLACE (State or foreign country) <u>Lithuania</u>	
13. FATHER'S NAME <u>Charles</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>220-44-7103</u>		17. INFORMANT <u>Anthony Garpstas</u>	
18. <u>41091</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>myocardial infarction</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>enlargement</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>enlargement</u>		ADDRESS <u>304 Bar Harbor Rd.</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>Jan 1952</u> to <u>12-7-72</u> that (I) (we) last saw the deceased alive on <u>12-7-72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Eugene Schmitter</u>				23B. DATE SIGNED <u>12-11-72</u>			
23C. PHYSICIAN'S NAME (Type) <u>EUGENE SCHMITTER</u>				23D. ADDRESS <u>3904 S. Hanover St</u> <u>Baltimore, Md. 21220</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-13-72</u>		24C. NAME of CEMETERY or CREMATORY <u>Holy Cross Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 14 1972</u>				25B. NAME OF REGISTRAR <u>Admiral</u>		25C. FUNERAL DIRECTOR <u>Hahn Funeral Home</u>	
						ADDRESS <u>4200 Pennington Ave.</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>W-252</u>		72 11813		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>72 11813</u>	
1. NAME OF DECEASED (Type or Print) <u>WIGGIN, MOLLIE</u>				2. DATE AND HOUR OF DEATH <u>DECEMBER 11, 1972</u> <u>8:00 P.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>				A. STATE <u>Maryland</u> B. COUNTY <u>2641</u>			
5. SEX <u>Female</u>				6. RACE <u>Caucasian</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<u>Housewife</u>				<u>Housewife</u>		<u>Maryland</u>	
13. FATHER'S NAME <u>XXXXX Richard Kolhway</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ellen Ebert</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>218 14 4612</u>		17. INFORMANT <u>4940 Eastern Avenue</u> <u>BCH: RECORDS Baltimore, Maryland 21224</u>	
18. <u>450X</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE <u>RESPIRATORY DISTRESS</u> DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <u>? Pulmonary embolism</u> DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(C) <u>Pneumonia</u>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
<u>2</u>		<u>-</u>		<u>YES</u>		<u>-</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
<u>12-11-72</u>		<u>While At Work</u>		<u>-</u>			
22. I certify that (I) (this hospital) attended the deceased from <u>12-26-72</u> 19 <u>72</u> to <u>12-11-72</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>12-11-72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>F. Wegley</u>				23B. DATE SIGNED <u>12-11-72</u>			
23C. PHYSICIAN'S NAME (Type) <u>F. Wegley, M.D.</u>				23D. ADDRESS <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue Baltimore, Maryland</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>Dec 15, 72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Dorsey Road, Washington Blvd</u>	
<u>Burial</u>		<u>Dec 15, 72</u>		<u>Meadowridge Cemetery</u>		<u>Dorsey Road, Washington Blvd</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 14 1972</u>		25B. NAME OF REGISTRAR <u>Lidney In...</u>		25C. FUNERAL DIRECTOR <u>McElly</u>		ADDRESS <u>237 Patapsco Ave 21225</u>	

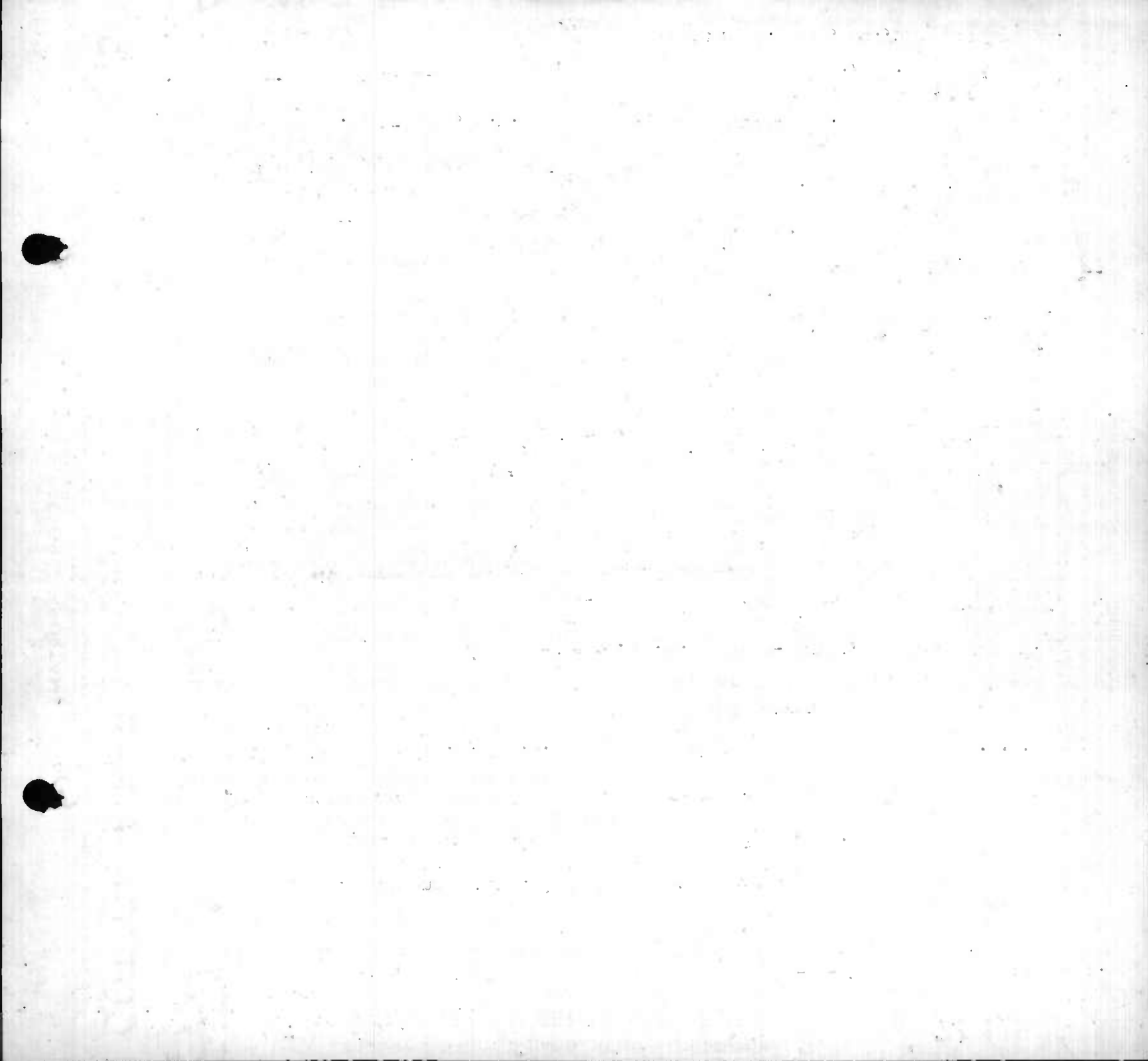
June 2nd

1881

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. <b>72 11814</b> <b>STATE OF MARYLAND - DEATH</b>	
BIRTH NO. <b>K-640</b> <b>72 11814</b>			
1. NAME OF DECEASED (Type or Print) <b>Arthur Kerl</b>		2. DATE AND HOUR OF DEATH <b>12-11-72</b>   <b>2:30</b> P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>90 Harford Gardens Nursing Home 4700 Harford Road Baltimore, Maryland 21214</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2702</b>	
		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>3020 Beverly Rd.</b>	
5. SEX <b>Male</b>	6. RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-18-1885</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Freight Conductor Ret. B&amp;O R.R.</b>		9. AGE (In years last birthday) <b>87</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Kerl</b>		14. MOTHER'S MAIDEN NAME <b>Ella Peterman</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>705-07-4220</b>	
		17. INFORMANT ADDRESS <b>Mrs. Florence Davis, 3020 Beverly Rd.</b>	
18. <b>412.4</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Coronary Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF: <b>ASCVD</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Several days</b>  <b>Several years</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>Dec. 5</b> 19 <b>72</b> to <b>Dec. 11</b> 19 <b>72</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>Dec. 11</b> 19 <b>72</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.			
23A. SIGNATURE  DEGREE		23B. DATE SIGNED <b>12/12/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Loy M. Zimmerman, M.D.</b> DEGREE		23D. ADDRESS <b>3202 Harford Rd.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>12-14-72</b>	24C. NAME OF CEMETERY or CREMATORY <b>Parkwood</b>	24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 14 1972</b>		25B. NAME OF REGISTRAR 	
25C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc., 5305 Harford Rd.</b>		ADDRESS	

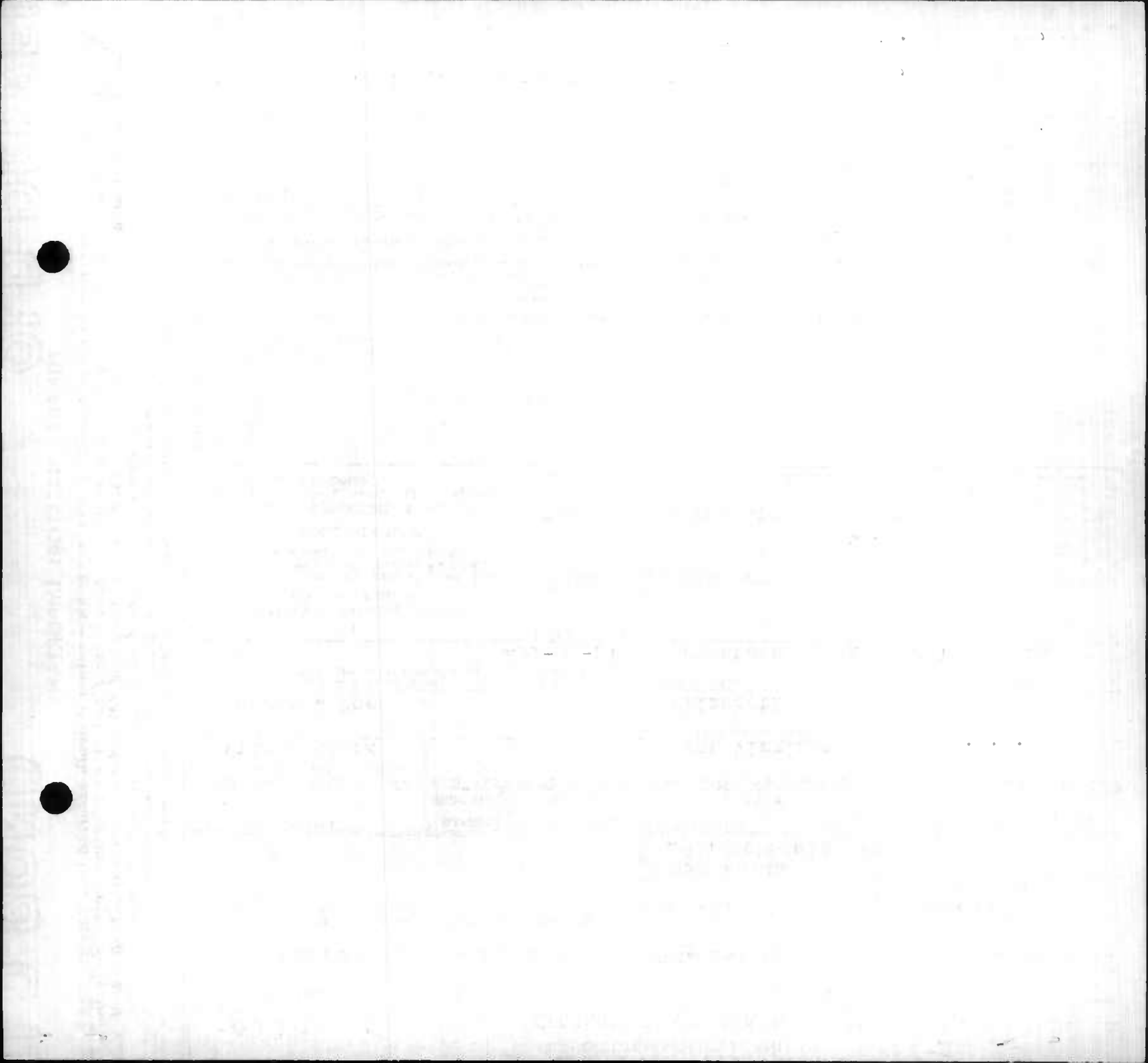


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-000		72 11815		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 11815	
BIRTH NO.		72 11815		STATE OF MARYLAND-DEPT		72 11815	
1. NAME OF DECEASED (Type or Print) <i>Watson B Poe Sr</i>				2. DATE AND HOUR OF DEATH <i>12/11/72 930 A</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <i>MD</i> B. COUNTY <i>2733</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>MD GEN HOSP</i>		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN <i>BALD</i>		D. (INSIDE CITY LIMITS?) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
48				E. STREET AND NUMBER <i>2901 Echodale Ave</i>			
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9/26/94</i>	9. AGE (In years last birthday) <i>78</i>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Clerk</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>West Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Curran L Poe</i>			14. MOTHER'S MAIDEN NAME <i>Elizabeth ?</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>233-09-5128</i>		17. INFORMANT ADDRESS <i>Mr Watson B Poe Jr 2619 Pelham Ave</i>		
18. <i>4712</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>M.I.</i> (B) <i>broncho pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>influenza</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>12</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>12/5</i> 19 <i>72</i> to <i>12/11</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>12/11/72</i> 19 <i>72</i> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Raymond A. Voth</i>				23B. DATE SIGNED <i>12/11/72</i>			
23C. PHYSICIAN'S NAME (Type) <i>MD GEN HOSP</i>				23D. ADDRESS <i>MD GEN HOSP BALD MD</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12/14/72</i>		24C. NAME of CEMETERY or CREMATORY <i>Gardens Of Faith</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 14 1972</i>		25B. NAME OF REGISTRAR <i>Lidsey</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Leonard J Ruck Inc. Baltimore, Md</i>			

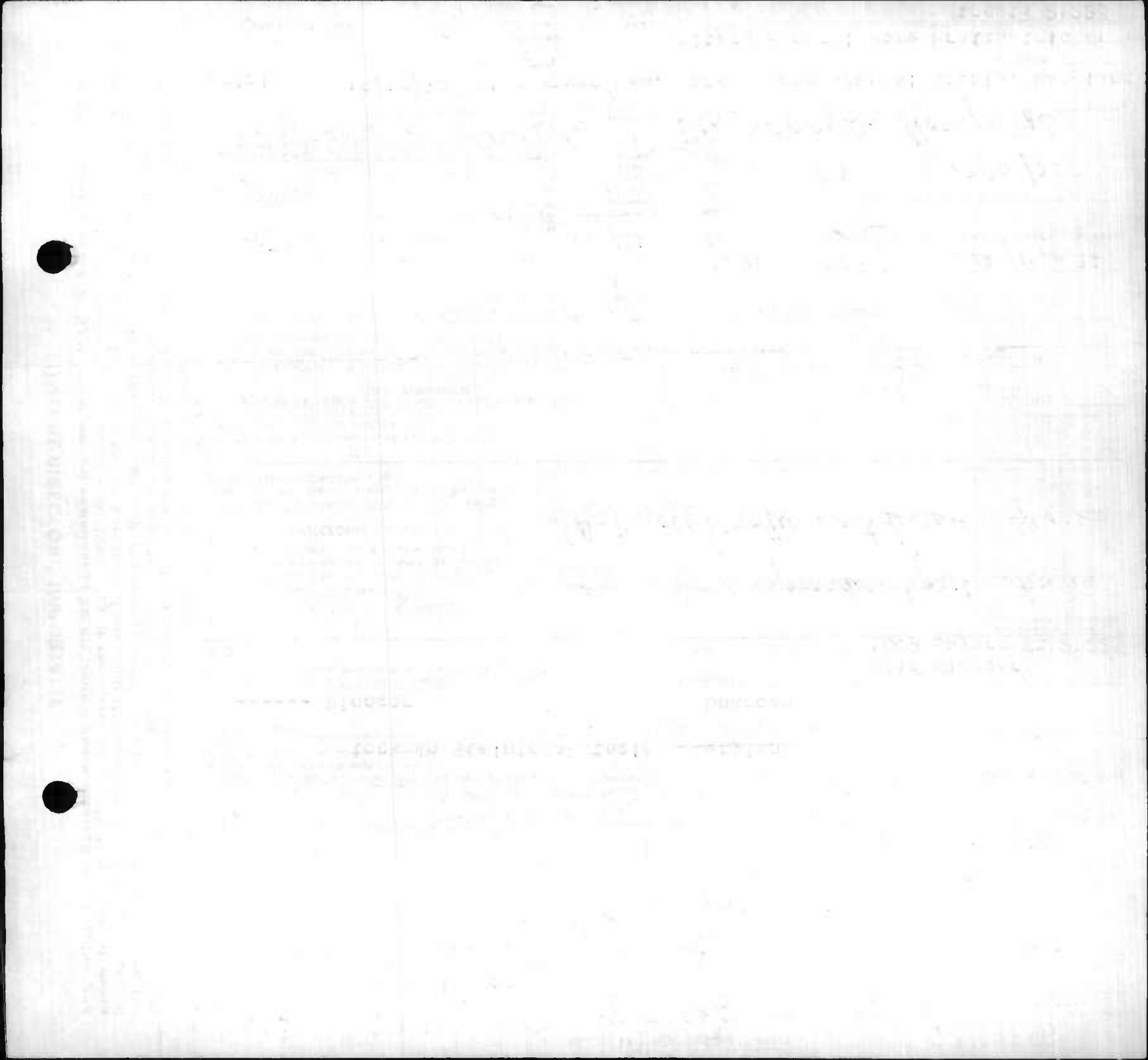




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

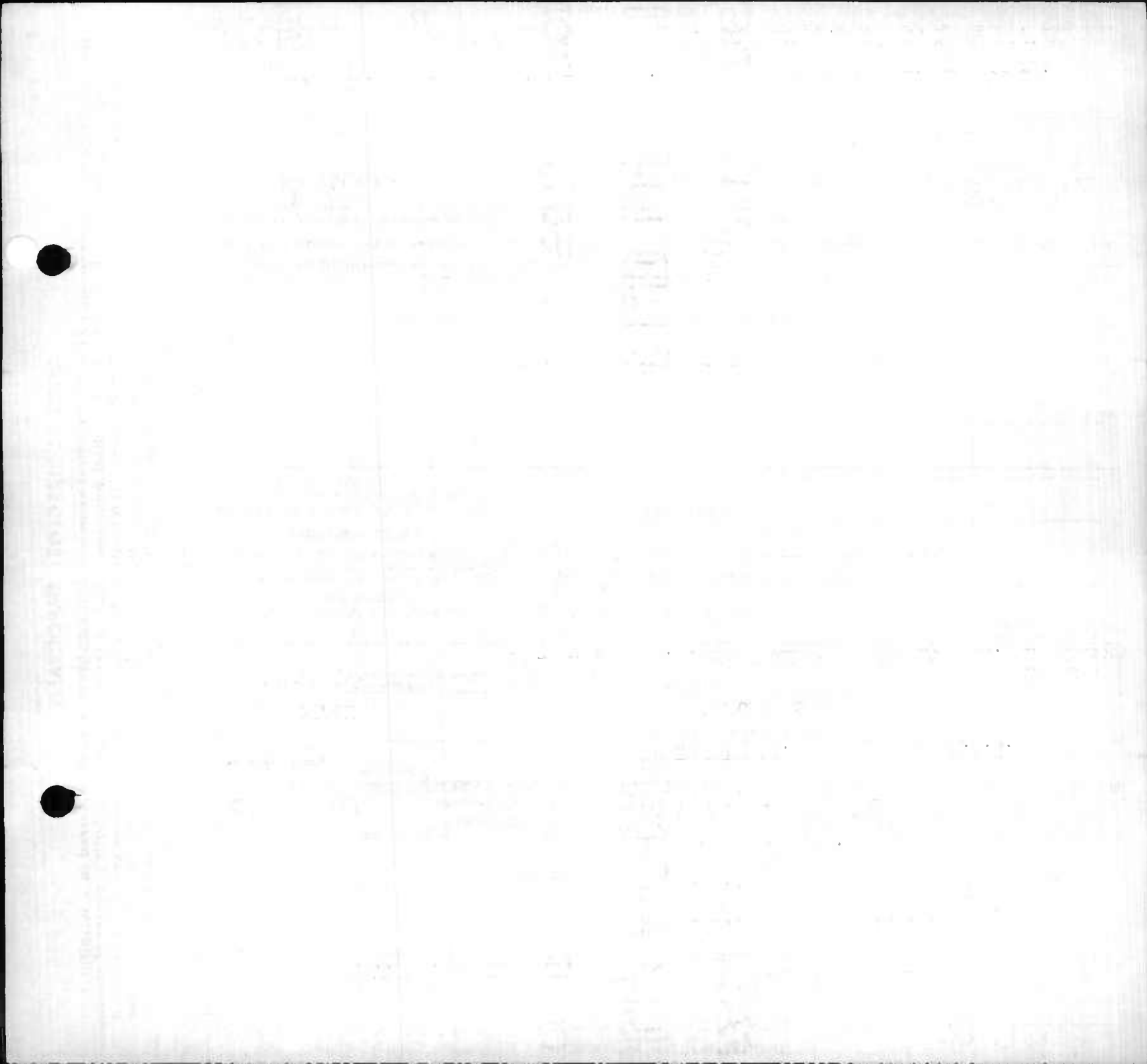
BIRTH NO. <u>W-532</u> 72 11816				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 11816	
1. NAME OF DECEASED (Type or Print) <u>Lacy Windsor</u>				2. DATE AND HOUR OF DEATH <u>12-11-72</u> <u>12:54</u> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>BON SECOURS HOSP 3025 W. Fayette St</u>				A. STATE <u>Baltimore</u>		B. COUNTY <u>2102</u>	
				C. CITY OR TOWN <u>MD</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>1009 Bayard St</u> 21223			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-9-98</u>	9. AGE (In years last birthday) <u>74</u>	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Stockman</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Stainless Steel</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>----- Windsor</u>			
14. MOTHER'S MAIDEN NAME <u>Unknown</u>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>218-01-1514</u>				17. INFORMANT <u>PT. CHART</u> ADDRESS <u>Ella Windsor 1009 Bayard St 21223</u>			
18. <u>410-91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE <u>Recent myocardial infarct</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Hours</u>			
ANTECEDENT CAUSES				(B) <u>Atherosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF: <u>years</u>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>0</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20A. AUTOPSY? (Yes or No) <u>No</u>				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>No</u>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Indicate medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			
21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?			
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that <u>(H) (this hospital)</u> attended the deceased from <u>12/10</u> 19 <u>72</u> to <u>12/11</u> 19 <u>72</u> that <u>(H) (we)</u> last saw the deceased alive on <u>12/11</u> 19 <u>72</u> and that in <u>(my) (our)</u> opinion death occurred on the date and hour and from the causes stated above. <u>(H) (We) (did) (did not)</u> view the body after death.							
23A. SIGNATURE <u>B Bon Secours</u>				23B. DATE SIGNED <u>12/11/72</u>			
23C. PHYSICIAN'S NAME (Type) <u>BONIFACIO B. ARANAS</u>				23D. ADDRESS <u>Bon Secours Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>12/13/72</u>			
24C. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem. Park</u>				24D. LOCATION (City, town, or county) (State) <u>Anne Arundel County, Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 14 1972</u>				25B. NAME OF REGISTRAR <u>Audrey Winston</u>			
25C. FUNERAL DIRECTOR <u>Walters Funeral Home Pratt &amp; Stricker</u>				ADDRESS <u>Streets 21223</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

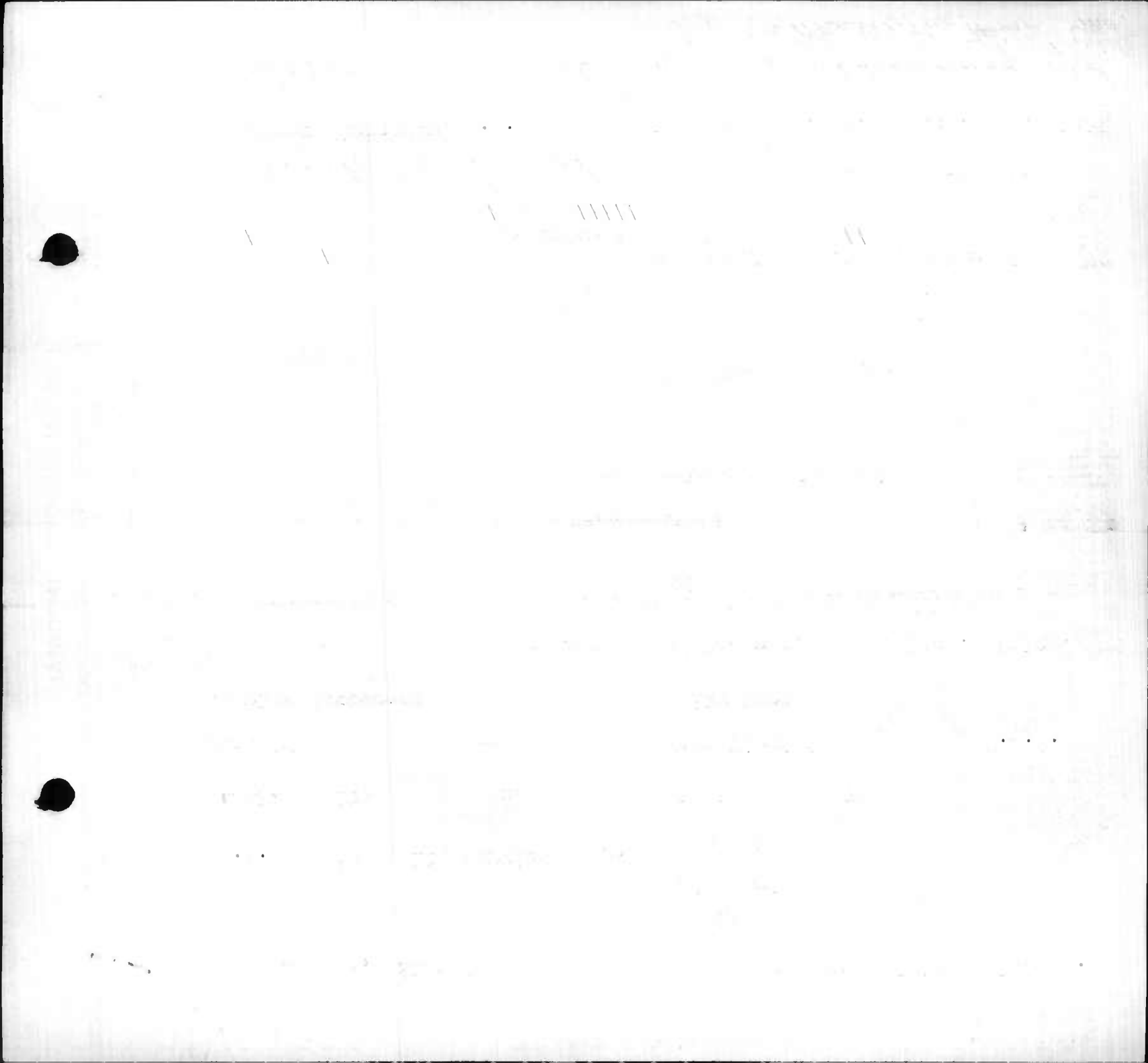
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 11817	
S-460 72 11817				STATE OF MARYLAND - DEPT. HEALTH	
BIRTH NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>SHELLER CLAUDIA</u>				Dec. 11, 1972 3 45 p.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <u>42 Sinai Hospital</u>				A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <u>RANDALLSTOWN</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>#8 SHERATON RD.</u>	
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>0.8/22/41</u>	9. AGE (In years last birthday) <u>31</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>			11. BIRTHPLACE (State or foreign country) <u>UNIONTOWN PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>ELMER KELLEY</u>			14. MOTHER'S MAIDEN NAME <u>FRANCES INKS</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>267-60-8453</u>		17. INFORMANT <u>Mr. Alvin Sheller #8 Sheraton Rd. Randallstown</u>
18. <u>571.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>LIVER FAILURE</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CHRONIC LIVER DISEASE, PROBABLY ALCOHOLIC</u>		
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C)		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12/02</u> 19 <u>72</u> to <u>12/12</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>12/12</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>R. Pinro</u>				23B. DATE SIGNED <u>Dec. 12/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>R. Pinro</u>				23D. ADDRESS <u>Sinai Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		24B. DATE <u>12/11/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Sanson Chapel Cem.</u>	
24D. LOCATION <u>Farmington Pa. Fayette Co.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 14 1972</u>			
25B. NAME OF REGISTRAR <u>Sidney Johnston</u>		25C. FUNERAL DIRECTOR <u>LOBBING BYERS FUNERAL DIRECTORS P.A.</u>			
25D. ADDRESS <u>8728 LIBERTY RD. RANDALLSTOWN, MD. 21133</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

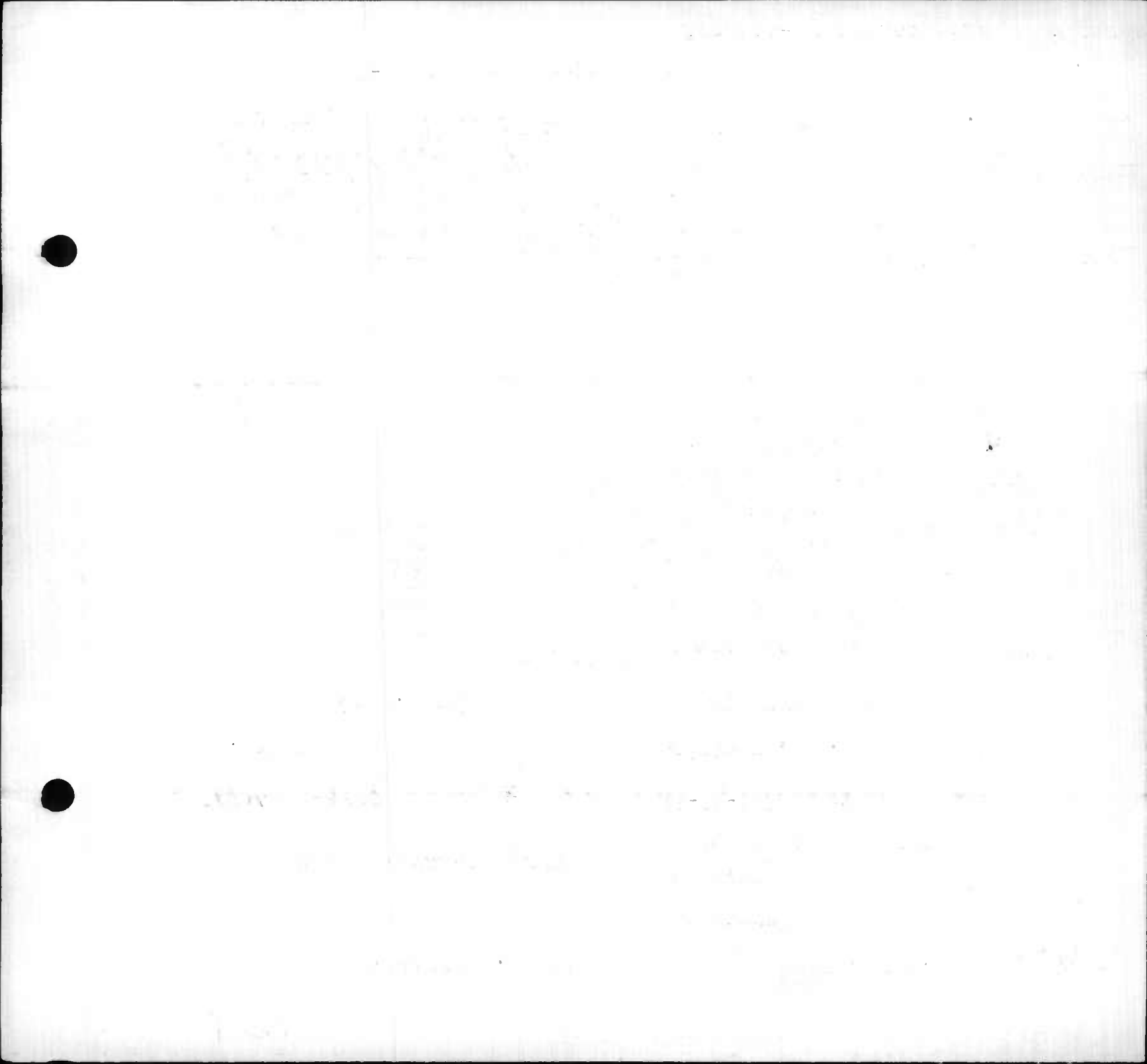
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 72-11818 STATE OF MARYLAND - DEPT. OF HEALTH	
BIRTH NO. <u>H-545</u> <u>72 11818</u>					
1. NAME OF DECEASED (Type or Print) <u>HANLIN, Hilda Roxanna</u>		2. DATE AND HOUR OF DEATH <u>December 8, 1972</u>   <u>1:30 A.</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>U.S. Public Health Service Hosp.</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>CARROLL</u> <u>5600</u>			
		C. CITY OR TOWN <u>Union Bridge</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>Route #1</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-15-1899</u>	9. AGE (In years last birthday) <u>73</u>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>	
13. FATHER'S NAME <u>Charles Ketterman</u>		14. MOTHER'S MAIDEN NAME <u>Emily Ours</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT ADDRESS <u>Med Records, US PHS Hosp., Balto., Md</u>	
18. <u>205.01</u> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			Pulmonary hemorrhage & consolidation (A) IMMEDIATE CAUSE <u>tion</u> DUE TO, OR AS A CONSEQUENCE OF:  (B) <u>Pancytopenia</u> DUE TO, OR AS A CONSEQUENCE OF:  (C) <u>Acute myelogenous leukemia</u>		
			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>  <u>6 Months</u>  <u>2 years</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>Yes</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>November 17</u> 19 <u>72</u> to <u>December 8</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>December 8</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Robert Kirschner M.D.</u>				23B. DATE SIGNED <u>12-8-72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Robert Kirschner, M.D.</u>				23D. ADDRESS <u>3100 Wyman Pk. Dr., Balto., Md. 21211</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>12-11-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Forest Oak</u>	
24D. LOCATION (City, town or county) (State) <u>Gatherburg Md</u>		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR <u>Jayson Wheeler</u>		25C. FUNERAL DIRECTOR <u>Rockville Md</u>			





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-580		72 11819		BALTIMORE CITY HEALTH DEPARTMENT		72 11819	
BIRTH NO.		72 11819		CERTIFICATE OF DEATH		REG. NO. 72 11819	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
FLORENCE D. JONES				DECEMBER 9, 1972 6:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
00 2301 PENTLAND DRIVE				MARYLAND			
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				2301 PENTLAND DRIVE			
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
FEMALE		WHITE		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11-25-1879	
						9. AGE (In years last birthday)	
						93	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Homemaker				Baltimore, Md.		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
John B. Doyle				Mary Frances Jackson			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
no		219 14 0374D		WILLIAM LEO JONES		same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		AS CVD - ch failure					
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO, OR AS A CONSEQUENCE OF:					
		Cerebral thrombosis & post stroke syndrome & left hemiplegia					
		(B) DUE TO, OR AS A CONSEQUENCE OF:					
		Carcinoma, nose & blood					
		(C) Metastatic Bronchopneumonia					
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from July 6, 1970 to Dec 9, 1972 that (I) (we) last saw the deceased alive on Dec 8, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
D. N. W. MINTZEN				Dec 10/1972			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
D. N. W. MINTZEN				3009 EVERGREEN AVE. BALTO 14 Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		12-1272		Greenmount Cemetery		Greenmount Ave Balto Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
DEC 14 1972		A. J. W. W. W. W.		MITCHELL-WIEDEFELD HOME		6500 YORK RD	



B-650

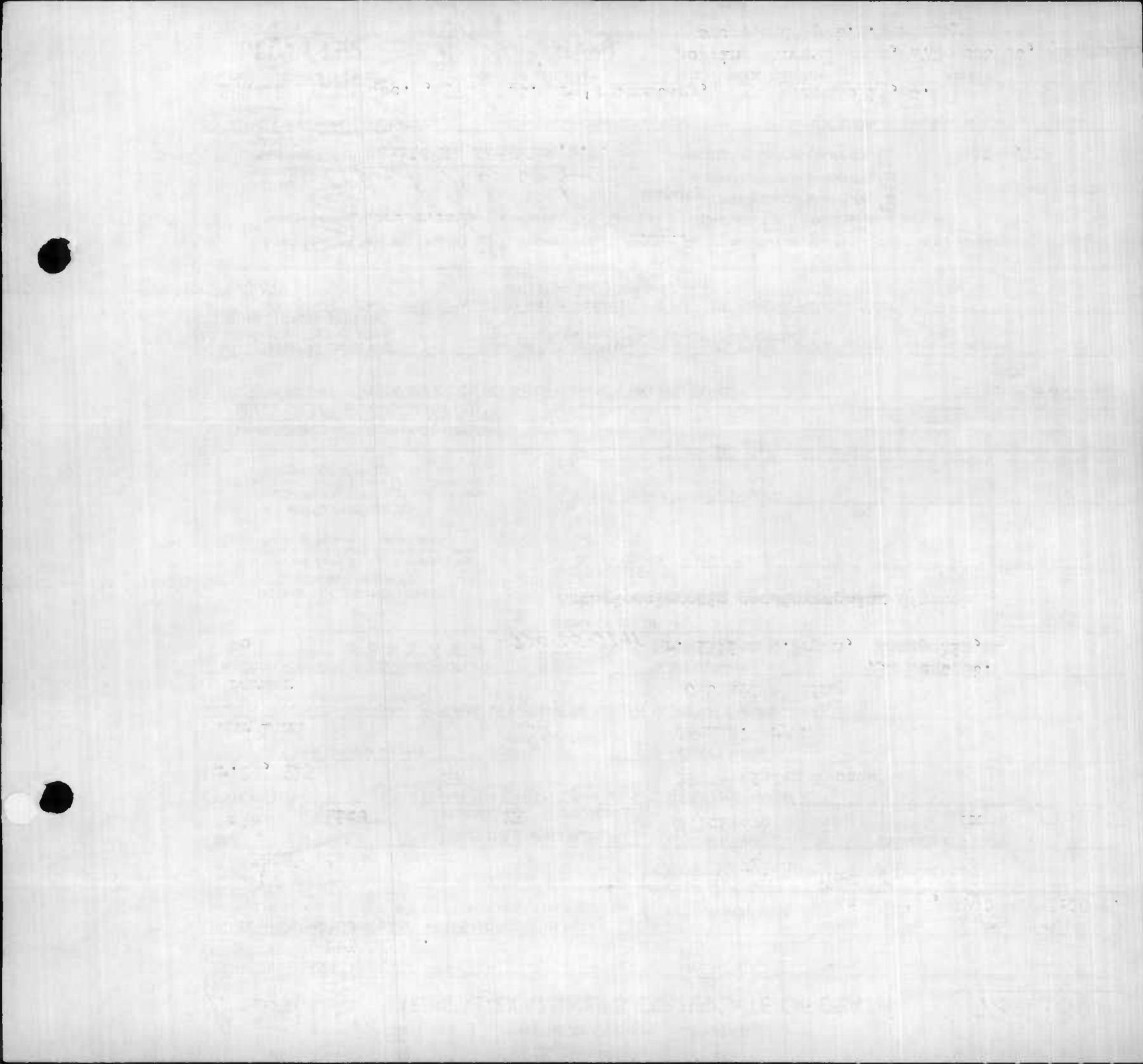
72 11820

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 11820

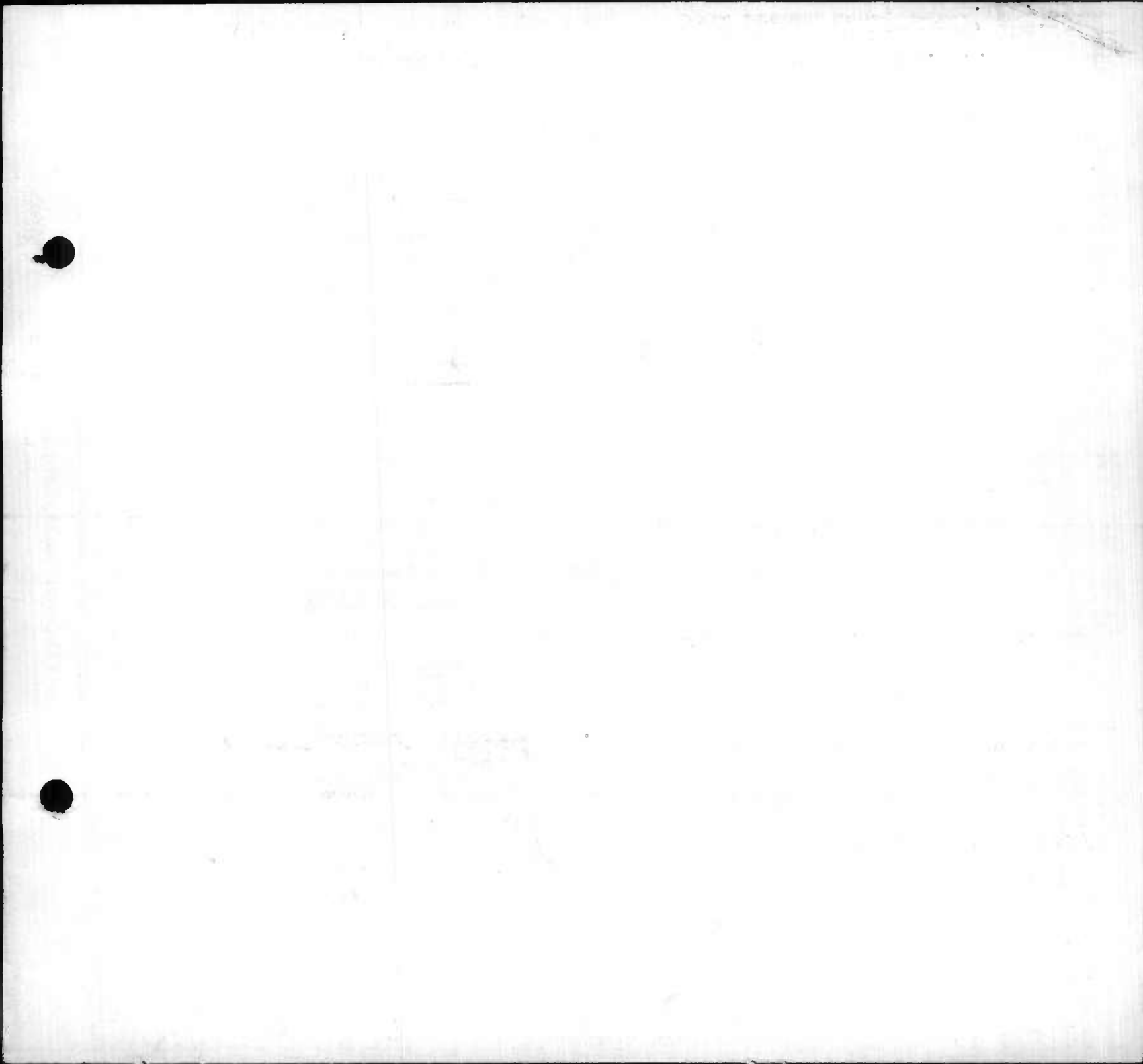
1. NAME OF DECEASED (Type or Print) <b>PHILLIP H. BRYAN</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>2225 1/2 Linden Avenue</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>December 4, 1972 5:30 P.M.</b>	
5. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1301</b>			
6. SEX <b>Male</b>	7. RACE <b>White</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>Mar. 23, 1915</b>		10. AGE (In years lost birthday) <b>57</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John E. Bryan</b>		14. MOTHER'S MAIDEN NAME <b>Catherine King</b>	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		16. KIND OF BUSINESS OR INDUSTRY	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		18. SOCIAL SECURITY NO. <b>220-05-2741</b>	
19. <b>412.41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH <b>Arteriosclerotic cardiovascular disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>12/5/72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>Dec. 8, 1972</b>	
24C. NAME OF CEMETERY or CREMATORY <b>St. Mary's Cemetery,</b>		24D. LOCATION (City, town, or county) (State) <b>Annapolis, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 14 1972</b>		25B. NAME OF REGISTRAR <b>Sidney Johnston</b>	
25C. FUNERAL DIRECTOR <b>Hopping Funeral Home, 172 West St, Annapolis</b>		25D. ADDRESS <b>172 West St, Annapolis</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

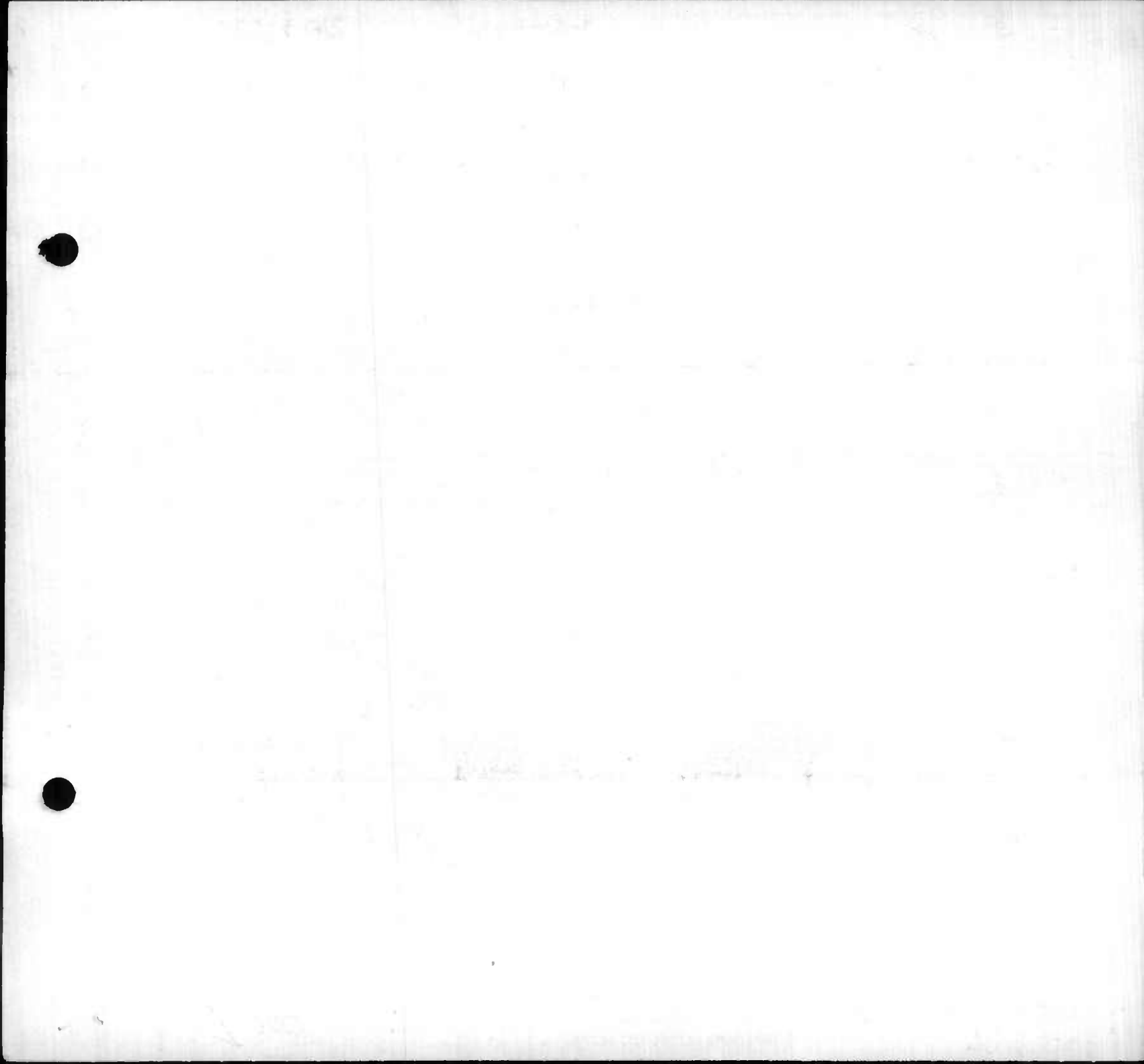
<div style="display: flex; justify-content: space-between;"> <span>B-500</span> <span>72 11821</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>		<div style="display: flex; justify-content: space-between;"> <span>REG. NO.</span> <span>72 11821</span> </div>
1. NAME OF DECEASED (Type or Print) <b>GEORGE H. RONEY</b>		2. DATE AND HOUR OF DEATH <b>12/9/72</b> <b>8 AM</b>
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>35 Church Home &amp; Hosp.</b>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>B Maryland</b> B. COUNTY <b>841</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3219. Clifton Ave, 21213</b>
5. SEX <b>Male</b> 6. RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-28-1901</b> 9. AGE (In years last birthday) <b>71</b> 10. UNDER 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired printer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>20th Century Printing Co.</b>
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>American</b>
13. FATHER'S NAME <b>George Roney</b>		14. MOTHER'S MAIDEN NAME <b>JEAN Mullan</b>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>215-09-0198</b>
17. INFORMANT <b>Gertrude Roney (wife) same address</b>		ADDRESS
18. CAUSE OF DEATH <b>410.81</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cardiac &amp; Pulmonary arrest</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Myocardial Infarction</b>		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Twp. Pulmonary metastasis for Ht-Block</b>		
19A. DATE OF OPERATION <b>0</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____ that (I) (we) last saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		
23A. SIGNATURE <b>M. Yousof Siddiqui MD</b>		23B. DATE SIGNED <b>12/9/72</b>
23C. PHYSICIAN'S NAME (Type) <b>M. Yousof Siddiqui MD</b>		23D. ADDRESS <b>Church Home &amp; Hosp 100 N. Broadway Balto MD 21231</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>12/12/72</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Cemetery</b>
24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 14 1972</b>
25B. NAME OF REGISTRAR <b>Sidney J. [Signature]</b>		25C. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b>
25D. ADDRESS <b>3331 Brooks Lane, Balto. Md. 21213</b>		



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 11822	
CERTIFICATE OF DEATH				STATE OF MARYLAND - DEPT.	
BIRTH NO. <b>7-200</b>		72 11822		REC. NO. <b>72 11822</b>	
1. NAME OF DECEASED (Type or Print) <b>JOHN L FOX</b>			2. DATE AND HOUR OF DEATH <b>12 12 72   3:40 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>35 Church Home &amp; Hospital</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>602</b>		
			C. CITY OR TOWN <b>CITY.</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>140 N. Lakewood Ave.</b>		
5. SEX <b>M</b>	6. RACE <b>N.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/4/92</b>	9. AGE (In years last birthday) <b>80</b>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman Retd.</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Vulcan Hart Mfg.</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>
13. FATHER'S NAME <b>? Fox</b>			14. MOTHER'S MAIDEN NAME <b>?</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes WWI</b>			16. SOCIAL SECURITY NO. <b>215-05-1334</b>		
			17. INFORMANT <b>Hospital chart</b>		
			ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>412.41</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cardio-Pulmonary Failure.</b> (B) <b>ASCVD &amp; CHF COPD</b> (C) <b>Respiratory Failure</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b> <b>Long standing</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>11/28/72</b> 19 <b>72</b> to <b>12/12</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>12/12</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE <b>Sagpal Singh M.D.</b>			23B. DATE SIGNED <b>12/12/72</b>		
23C. PHYSICIAN'S NAME (Type) <b>SATPAL SINGH M.D.</b>			23D. ADDRESS <b>Church Home &amp; Hospital</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/15/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>	
				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 14 1972</b>		25B. NAME OF REGISTRAR <b>Sidney Whitson</b>		25C. FUNERAL DIRECTOR <b>John A. Moran, Inc.</b>	
				ADDRESS <b>3000 E. Baltimore St. Baltimore, Md. 21224</b>	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/6B

1914

OFFICE OF THE SECRETARY OF THE ARMY

WASHINGTON, D. C.

TO THE SECRETARY OF THE ARMY

FROM THE SECRETARY OF THE ARMY

SUBJECT: [Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 72 11824	
BIRTH NO. S-455 72 11824				STATE OF MARYLAND-DEMD			
1. NAME OF DECEASED (Type or Print) <i>Skillman, Herman</i>				2. DATE AND HOUR OF DEATH <i>11 Dec 72 10:20 P</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>University of Maryland Hospital</i>				A. STATE <i>Maryland</i> B. COUNTY <i>HAR.</i>		C. CITY OR TOWN <i>Aberdeen</i>	
CERTIFICATE AMENDED				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
				E. STREET AND NUMBER <i>Rt. 1 Box 187</i>			
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>2-18-14</i>	9. AGE (in years last birthday) <i>58</i>	10. UNDER 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sheetmetal Worker</i>				10B. KIND OF BUSINESS OR INDUSTRY <i>construction</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>Arthur A. Skillman</i>				14. MOTHER'S MAIDEN NAME <i>Elizabeth Handel</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>				16. SOCIAL SECURITY NO. <i>705-09-7565</i>		17. INFORMANT <i>Sylvia Skillman, Rt. 1, Box 187, Aberdeen Md.</i>	
18. <i>430.9 H 303.9</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
<p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>				(A) IMMEDIATE CAUSE <i>Pulmonary Arrest</i>		<i>10 min</i>	
				(B) <i>Sub Arachnoid Hemorrhage</i>		<i>3 hr.</i>	
				(C) <i>Cranio-cerebral Trauma</i>		<i>3 hr.</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>Alcoholism + Hypertensive Cardiovascular Disease</i>							
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from <i>9/5</i> 19 <i>72</i> to <i>12/11</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>12/11</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>J. A. Ziegler M.D.</i>				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) <i>J. A. Ziegler M.D.</i>				23D. ADDRESS <i>University of Maryland Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Dec. 15, 1972</i>		24C. NAME OF CEMETERY OR CREMATORY <i>St. Francis Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Abingdon Harford Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 14 1972</i>		25B. NAME OF REGISTRAR <i>Anthony Wharton</i>		25C. FUNERAL DIRECTOR <i>Howard K. McComas, III</i>		ADDRESS <i>Abingdon, Md.</i>	

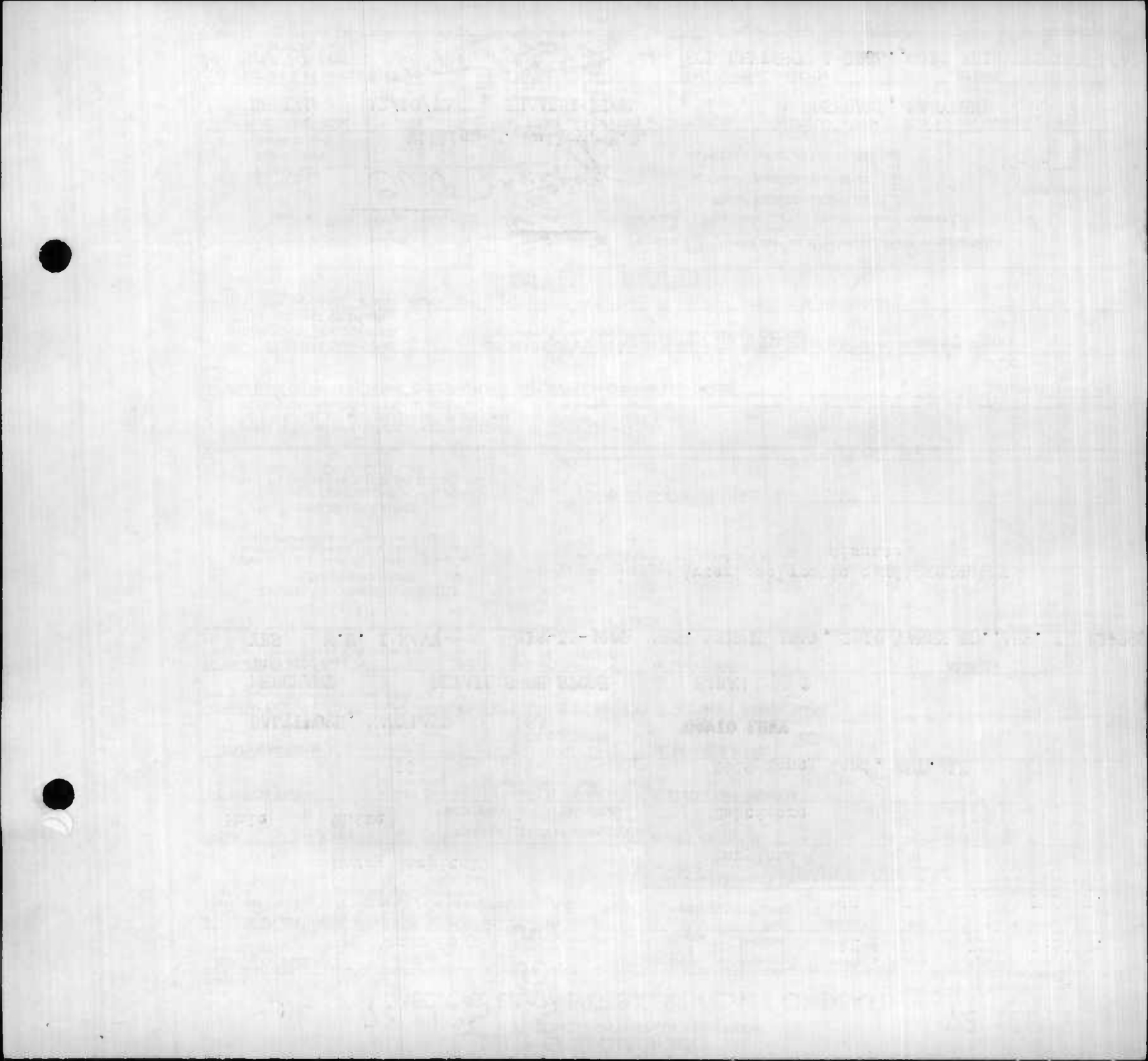
12-21-1972 - Correction letter from Howard K. McComas III Funeral Home, Box 137,  
Cokesbury Road, Abingdon, Maryland 21009 (by Nena S. McComas) hs

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

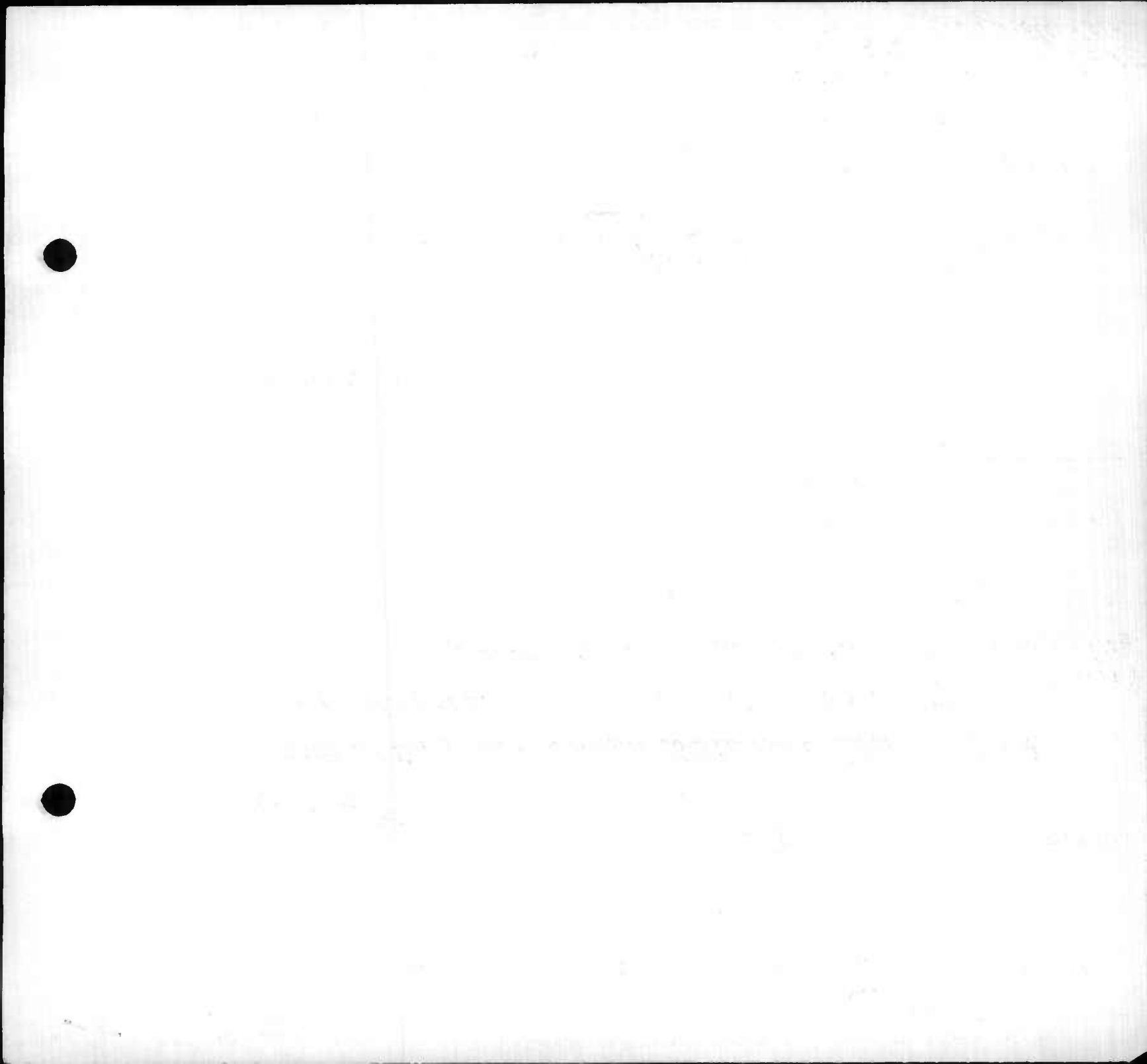
1. NAME OF DECEASED (Type or Print) Oscar Levy		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 12 8 72 7:54 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 Mercy Hospital		3. DATE PRONOUNCED DEAD Month Day Year 12 8 72 7:54 P. M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2740	
9. DATE OF BIRTH		10. AGE (In years last birthday) 76	
11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT		14B. KIND OF BUSINESS OR INDUSTRY RETAIL SHOE STORE	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W. I NAVY		17. SOCIAL SECURITY NO. 218-32-4089	
18. INFORMANT MRS. MINNIE LEVY, 2910 TANEY RD., APT. 1B #21209		ADDRESS	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE William P. Mulloy, M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12-9-72			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/10/72	
24C. NAME OF CEMETERY or CREMATORY SHAAREI ZION		24D. LOCATION (City, town, or county) (State) ROSEDALE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. DEC 14 1972		25B. NAME OF REGISTRAR Arlene H. Hester	
25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		ADDRESS	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

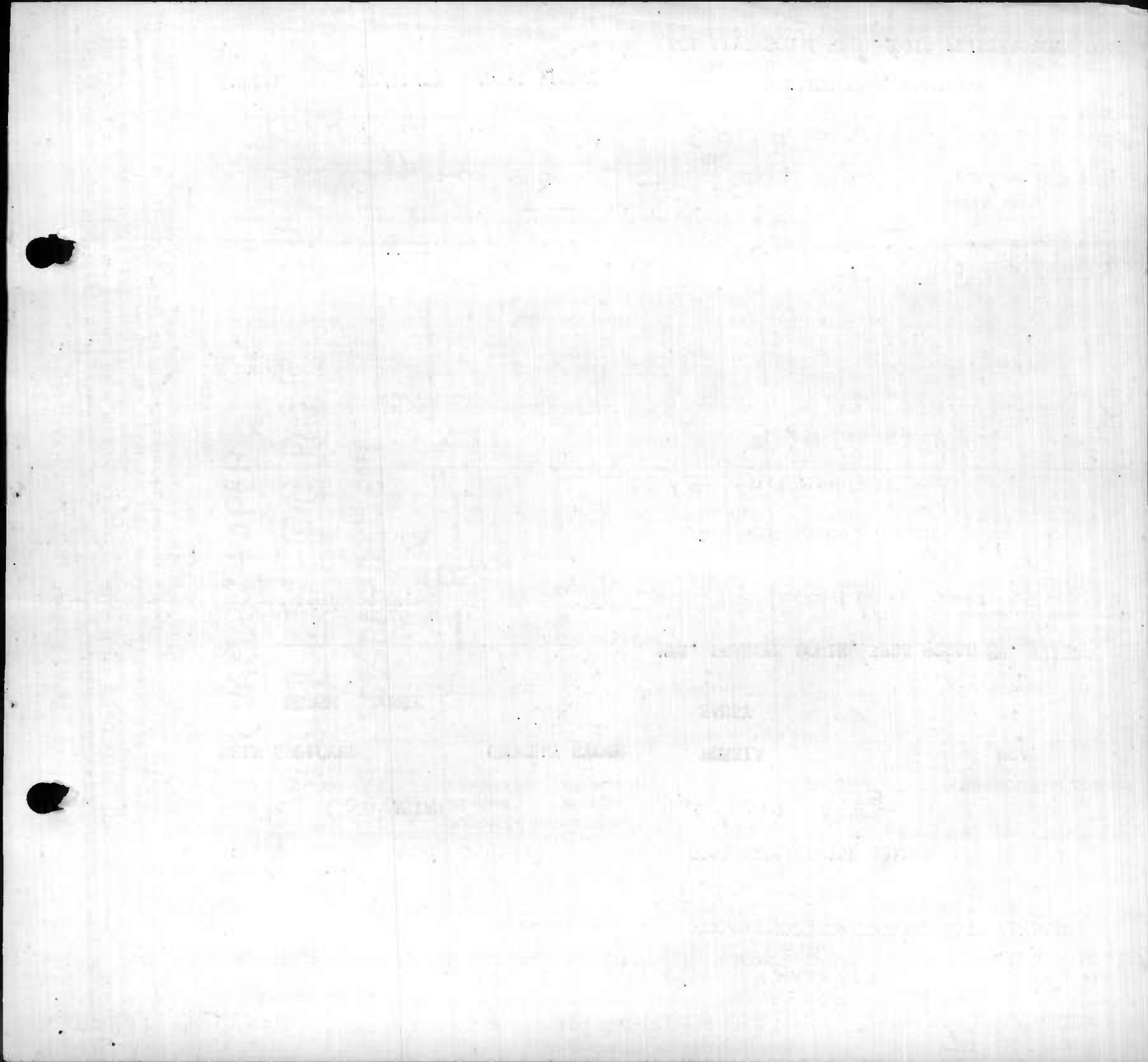
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
M-534		72 11826		72 11826	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		STATE OF MARYLAND	
HERMAN MANDEL		12/9/72 10 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE		B. COUNTY	
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		MD.		BALTO	
SINAI HOSPITAL BALTO.		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		6998 MARQUE DR. #15.			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
MALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	01/16/06	66	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
RETIRED TAILOR - SELF EMPLOYED				Baltimore Md.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
HARRY MANDEL		Pearl Markowitz		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
NO		220-32 3079		Selma Mandel - 6998 Marquet Dr. Apt 1D	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenic, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		CARDIO RESPIRATORY ARREST.	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		ACUTE ANEMIA (RECTAL BLEEDING)	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:		BOWEL RESECTION	
II		PARKINSON DISEASE			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
11/19/72		Incarcerated ing. hernia		NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 11/19/72 19 to 12/9/72 19 that (I) (we) last saw the deceased alive on 12/9/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
ROBERTO FRIDMAN		12/9/72			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
		SINAI HOSPITAL BALTO.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		Dec 10/72		Chesek Amuro	
24D. LOCATION (City, town, or county)		24E. STATE			
Baltimore, Md.		BALTO			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
DEC 14 1972		Sidney W. Horton		Selma Mandel - 6998 Marquet Dr. Apt 1D	
VS NO. REV. 1/76					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

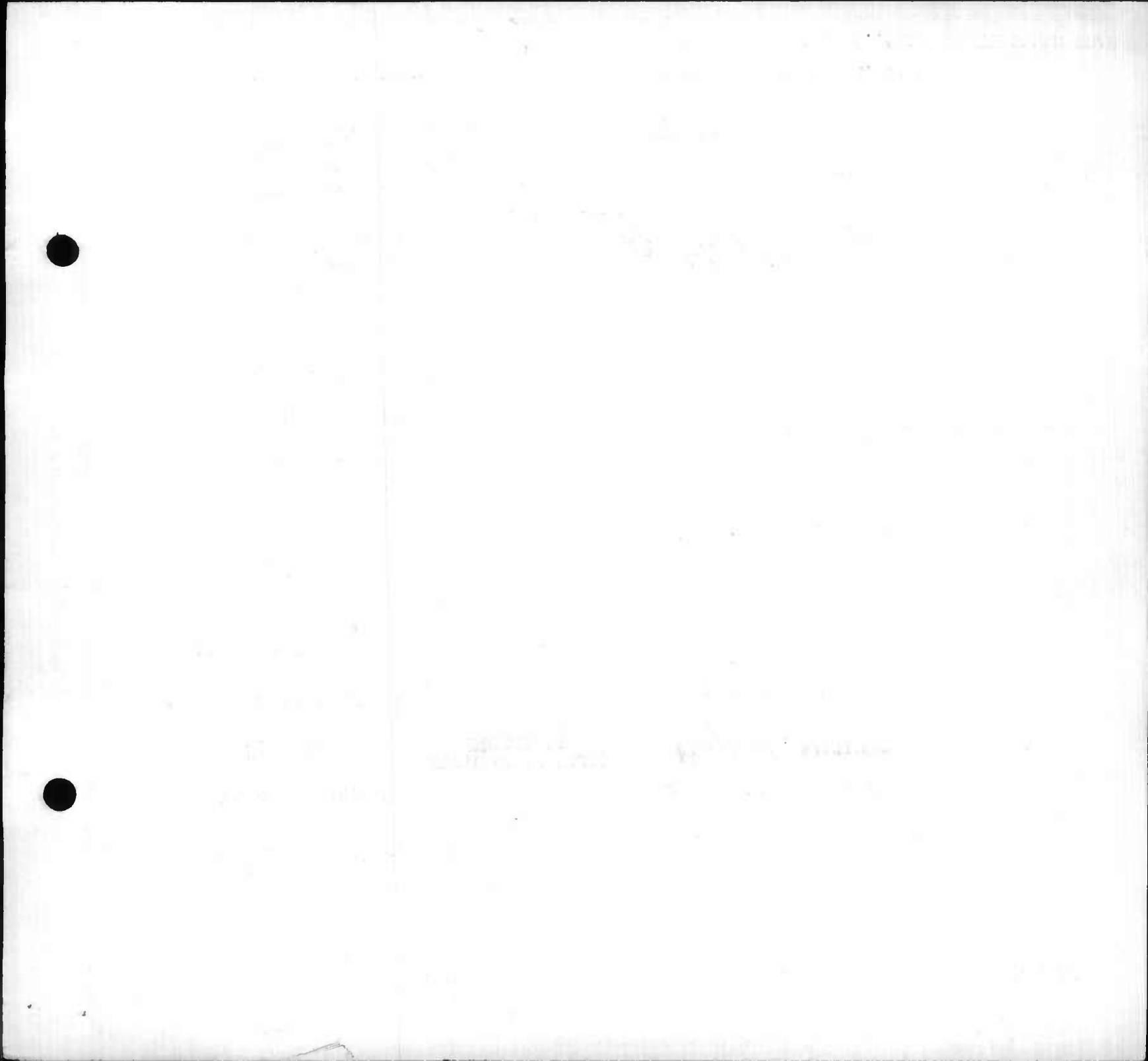
D-520		72 11827		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 11827	
BIRTH NO.		72 11827		CERTIFICATE OF DEATH		STATE OF MARYLAND, DEPT. OF HEALTH	
1. NAME OF DECEASED (Type or Print) <b>Donik, Louis</b>				2. DATE AND HOUR OF DEATH <b>12-10-72</b> <b>230 A</b> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Sinai Hospital Baltimore Md 21215</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3203 SZOLD DRIVE #21208</b>			
5. SEX <b>male</b>	6. RACE <b>CAUCASIAN</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 18 1897</b>	9. AGE (In years last birthday) <b>75</b>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SELF EMPLOYED</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>GROCERY STORE</b>		11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>HERSH DONIK</b>				14. MOTHER'S MAIDEN NAME <b>SAUSY</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MRS. FRANCES DONIK, 3203 SZOLD DR. #21208</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>413.91 + 250.9</b> CAUSE OF DEATH <b>CARDIAC ARREST</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Diabetes mellitus</b>							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>12-9</b> 19 <b>72</b> to <b>12-10</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>12-10</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Gian Caggiano MD</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10 Dec 1972</b>	
23C. PHYSICIAN'S NAME (Type) <b>GIAN CAGGIANO MD.</b>				23D. ADDRESS <b>Sinai Hospital Baltimore Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12/11/72</b>		24C. NAME of CEMETERY or CREMATORY <b>ANSHE EMUNAH</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 14 1972</b>		25B. NAME OF REGISTRAR <b>Sol Levinson</b>		25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 11828		REG. NO. 72 11828	
BIRTH NO. S-351		72 11828		STATE OF MARYLAND, DELIC	
1. NAME OF DECEASED (Type or Print) <b>Jacob Steinberg</b>		2. DATE AND HOUR OF DEATH <b>December 10, 1972 4 AM</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>US Public Health Service Hospital Baltimore, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Glen Burnie</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>US Public Health Service Hospital Baltimore, Maryland</b>		C. CITY OR TOWN <b>Glen Burnie</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Male</b>		6. RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plumber</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>STATE OF MARYLAND</b>		8. DATE OF BIRTH <b>3-15-44</b>	
13. FATHER'S NAME <b>Israel Steinberg</b>		14. MOTHER'S MAIDEN NAME <b>Helen Evnitz</b>		9. AGE (In years last birthday) <b>28</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>XXXXXXXXXX</b>		16. SOCIAL SECURITY NO. <b>212-42-3227</b>		17. INFORMANT <b>Patient</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>484X1+186X</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Respiratory failure</b> (B) <b>Diffuse interstitial pneumonitis</b> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>1 week</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Testicular carcinoma with metastases to months</b>					
19A. DATE OF OPERATION <b>11/2/9/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Pneumonitis</b>		20A. AUTOPSY? (Yes or No) <b>None</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (it) (this hospital) attended the deceased from <b>12/1/72</b> 19 to <b>12/10/72</b> 19 that (it) (we) last saw the deceased alive on <b>12/2/72</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Paul Chang, MD</b>		23B. DATE SIGNED <b>12/10/72</b>		23C. PHYSICIAN'S NAME (Type) <b>Paul Chang, MD</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12/11/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>HAR ZION TIFERETH ISRAEL</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 14 1972</b>		25B. NAME OF REGISTRAR <b>Andrew Winston</b>		25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>	
24D. LOCATION (City, town, or county) <b>ROSEDALE, MARYLAND</b>		24E. ADDRESS <b>3100 Wyman Park Drive</b>			

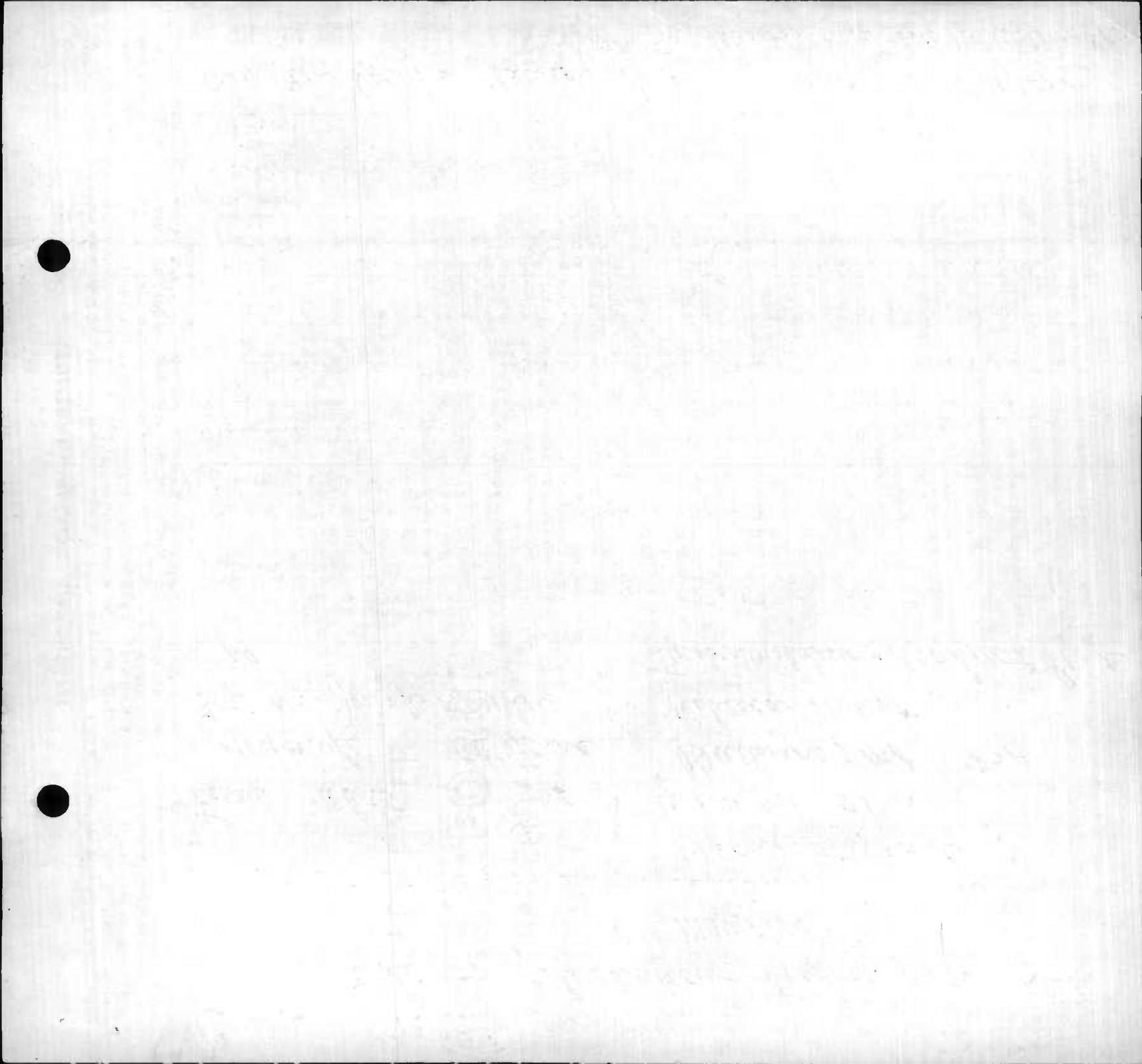


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 72 11829	
G-422 72 11829				CERTIFICATE OF DEATH	
BIRTH NO.				STATE OF MARYLAND-DEMD	
1. NAME OF DECEASED (Type or Print) <i>Eleanor Blushakow</i>			2. DATE AND HOUR OF DEATH <i>December 10/72 5<sup>30</sup> P. M.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>1920 South Road</i>			A. STATE <i>Maryland</i> B. COUNTY <i>2755</i>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <i>Baltimore</i>		
			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER <i>1920 South Road</i>		
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 26, 1921</i>	9. AGE (In years last birthday) <i>51</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>
108. KIND OF BUSINESS OR INDUSTRY <i>at home</i>			11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Late Dr. Joseph Kemler</i>			14. MOTHER'S MAIDEN NAME <i>Rebecca Macht</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give War or dates of service) <i>No</i>			16. SOCIAL SECURITY NO.		17. INFORMANT <i>Jacob Blushakow - 1920 South Road</i>
18. <i>174X I</i>			CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Metastatic carcinoma breast</i>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0 1969</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Breast tumor</i>		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Sept 1972</i> to <i>Dec 10 1972</i> , that (I) (we) last saw the deceased alive on <i>Dec 9 1972</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Herbert N. Gundersheimer</i>				23B. DATE SIGNED <i>12-11-72</i>	
23C. PHYSICIAN'S NAME (Type) <i>HERBERT N. GUNDERSHEIMER</i>				23D. ADDRESS <i>2601 Madison Ave</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Cremation</i>		24B. DATE <i>Dec 12/72</i>		24C. NAME of CEMETERY or CREMATORY <i>Linden Park</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>DEC 14 1972</i>			
25B. NAME OF REGISTRAR <i>Sidney Johnston</i>		25C. FUNERAL DIRECTOR <i>Sal Lunnin &amp; Sons - 6010 Reisterstown Rd</i>			





STATE OF MARYLAND - DEPT. OF HEALTH  
BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
REG. NO. 72 11830

1. NAME OF DECEASED (Type or Print) Edith Spitzer		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 12 8 72 5:10 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 St. Agnes Hospital		3. DATE PRONOUNCED DEAD Month Day Year 12 8 72 5:10 P. M.	
6. SEX Female		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Arlington	
9. DATE OF BIRTH JANUARY 22, 1940		10. AGE (In years last birthday) 32	
11. BIRTHPLACE (State or foreign country) PITTSBURG, PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME DAVID SWARTZ		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	
15. MOTHER'S MAIDEN NAME EVELYN CAPLAN		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO	
17. SOCIAL SECURITY NO.		18. INFORMANT MR. ALVIN SPITZER, 2301 S. JEFFERSON DAVIS HWY	
19. E 8 / 2.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Multiple injuries (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No		22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? I-95 at State Rte. 175	
22D. TIME OF INJURY (APPROX.) 12 8 72 4:30 P. M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? Passenger in auto which struck stalled auto		23.	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) William P. Mulloy, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 12-8-72		24A. BURIAL CREMATION, REMOVAL (Specify) VAL-BURIAL	
24B. DATE 12/10/72		24C. NAME OF CEMETERY or CREMATORY WORKMENS CIRCLE	
24D. LOCATION (City, town, or county) (State) MILLVALE, PENNSYLVANIA		25A. DATE REC'D BY HEALTH DEPT. DEC 14 1972	
25B. NAME OF REGISTRAR Sidney Johnston		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

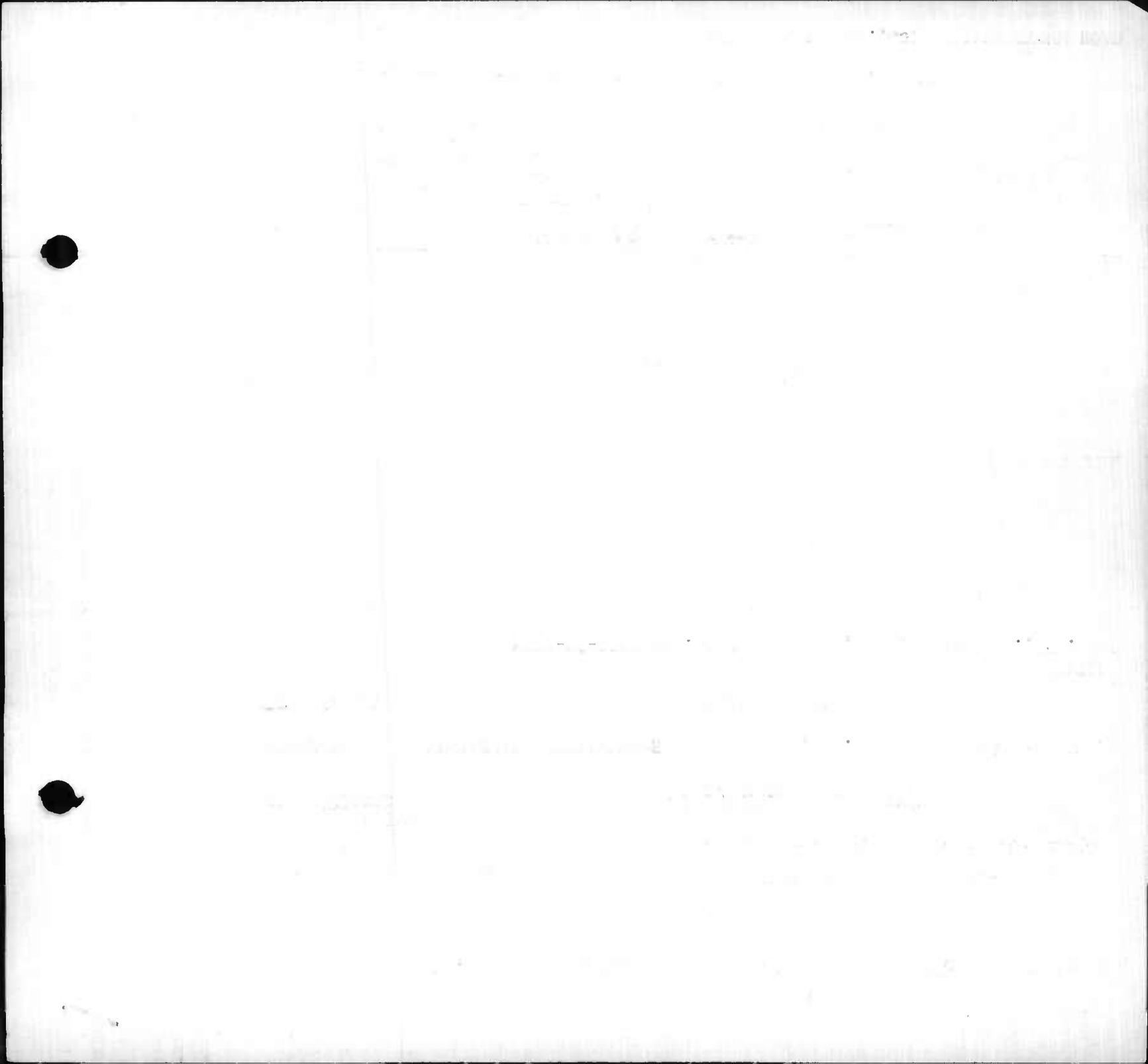
S-100

72 11831

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 72 11831  
STATE OF MARYLAND-DEPT. OF HEALTH

1. NAME OF DECEASED (Type or Print) <b>Shubow, Harold</b>		2. DATE AND HOUR OF DEATH, <b>Dec. 7, 1972 8:20 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>SINAI HOSP. OF BALTIMORE</b>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>M.D.</b> B. COUNTY <b>2831</b>	
5. SEX <b>MALE</b>		6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MERCHANT</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>WHOLESALE DISTRIBUTORS</b>	
13. FATHER'S NAME <b>MEYER SHUBOW</b>		14. MOTHER'S MAIDEN NAME <b>ANNA SHULMAN</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>k371-22-7782</b>	
17. INFORMANT <b>MRS. JENNIE SHUBOW</b>		ADDRESS <b>#21215</b> <b>6632 EBERLE DR., APT. 204</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>cardio pulmonary shock?</b> <b>nephric shock?</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>1) Aortic aneurysm.</b> <b>2) resected adenocarcinoma of caecum without</b> <b>3) post-operative obstruction released by surgery</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>10/19/72, 11/5/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Ca. ascending colon, Lymphadenitis</b>	
20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>10/19/72</b> to <b>12/7/72</b> and that (I) (we) last saw the deceased alive on <b>12/7/72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Hubert L. Eveque</b>		23B. DATE SIGNED <b>12/7/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>HUBERT L. EVEQUE</b>		23D. ADDRESS <b>Sinai Hospital of Baltimore</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12/10/72</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>CHIZUK AMINO (ARLINGTON)</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 14 1972</b>		25B. NAME OF REGISTRAR <b>Sidney L. Weston</b>	
25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS.</b>		ADDRESS <b>6010 REISTERSTOWN ROAD</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>H-156</b>		72 11832		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>72 11832</b>	
1. NAME OF DECEASED (Type or Print) <b>EMILE HAEFFNER</b>				2. DATE AND HOUR OF DEATH <b>12/8/72 900 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>33 Johns Hopkins Hospital 601 N Broadway</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2788</b> C. CITY OR TOWN <b>BALTIMORE City</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>5327 Nelson Ave. 21215</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/12/99</b>	9. AGE (In years last birthday) <b>73</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Appliances</b>		11. BIRTHPLACE (State or foreign country) <b>BALTO Maryland.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>SIMON HAEFFNER</b>				14. MOTHER'S MAIDEN NAME <b>ANNA HERBSTMAN</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>5716 RANNY RD. #21209</b> ADDRESS <b>Brother - <del>Emile</del> LEON Haeffner</b>			
18. <b>410.91 + 150.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>Cardiac Arrest</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Probable Myocardial Infarction 2-3 hrs.</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>S/P Several Myocardial Infarctions - years</b> (C) <b>Diabetes Mellitus, Severe ASCVD years</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>12/1</b> 19 <b>72</b> to <b>12/8</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>12/8</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>J. Raymond DePauls MD</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>12/8/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>J. Raymond DePauls MD</b>				23D. ADDRESS <b>Johns Hopkins Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12/10/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>MOGAN ABRAHAM</b>		24D. LOCATION (City, town, or county) (State) <b>ROSEDALE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 14 1972</b>		25B. NAME OF REGISTRAR <b>Sidney Winston</b>		25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>			

RECEIVED: NATIONAL ARMY MUSEUM

RECEIVED: ARMY MUSEUM

ON 10/10/1910

UNITED STATES ARMY

WASHINGTON, D.C.

RECEIVED: ARMY MUSEUM

VIS

RECEIVED

EX-112

EX-112

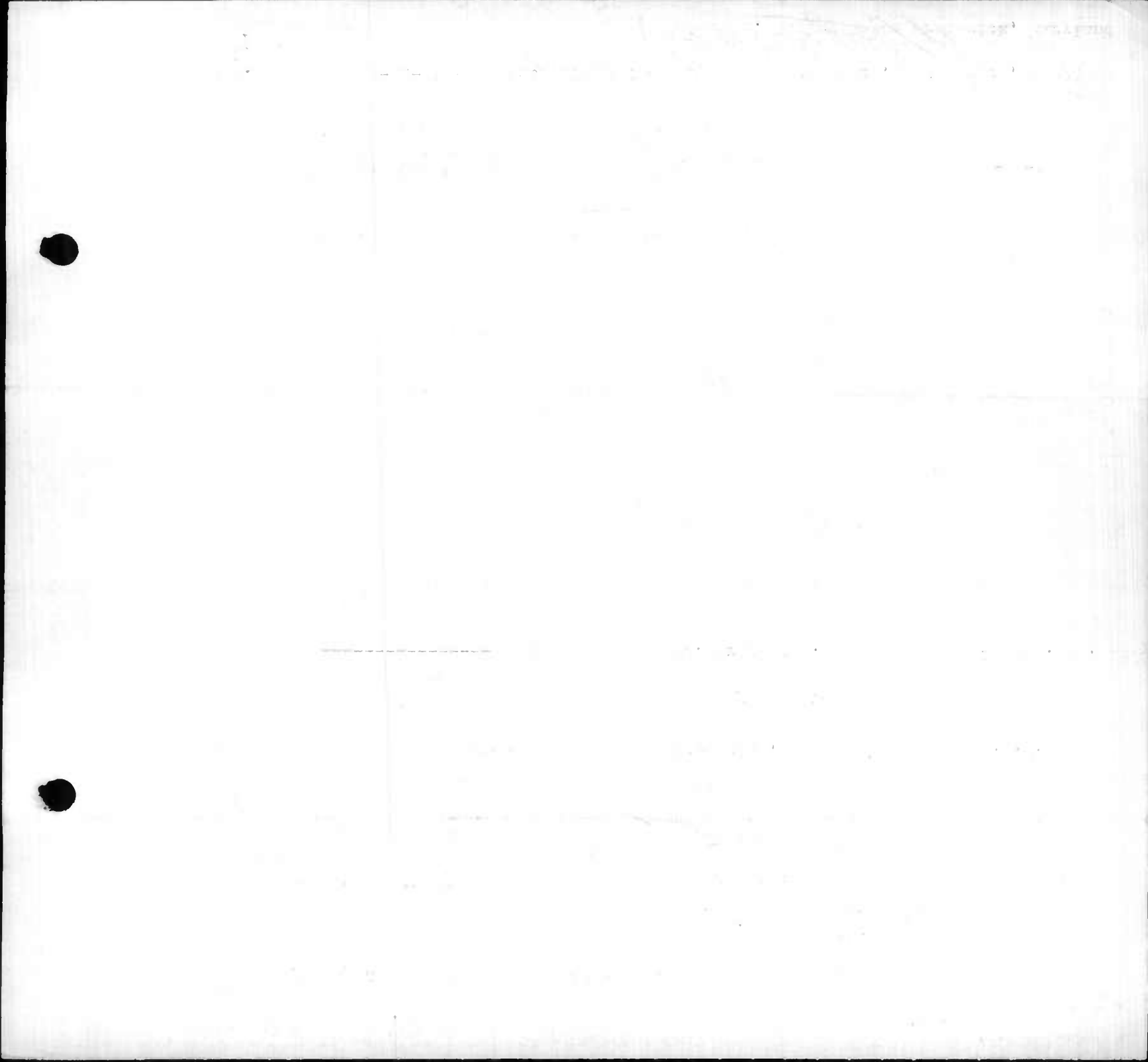
EX-112



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

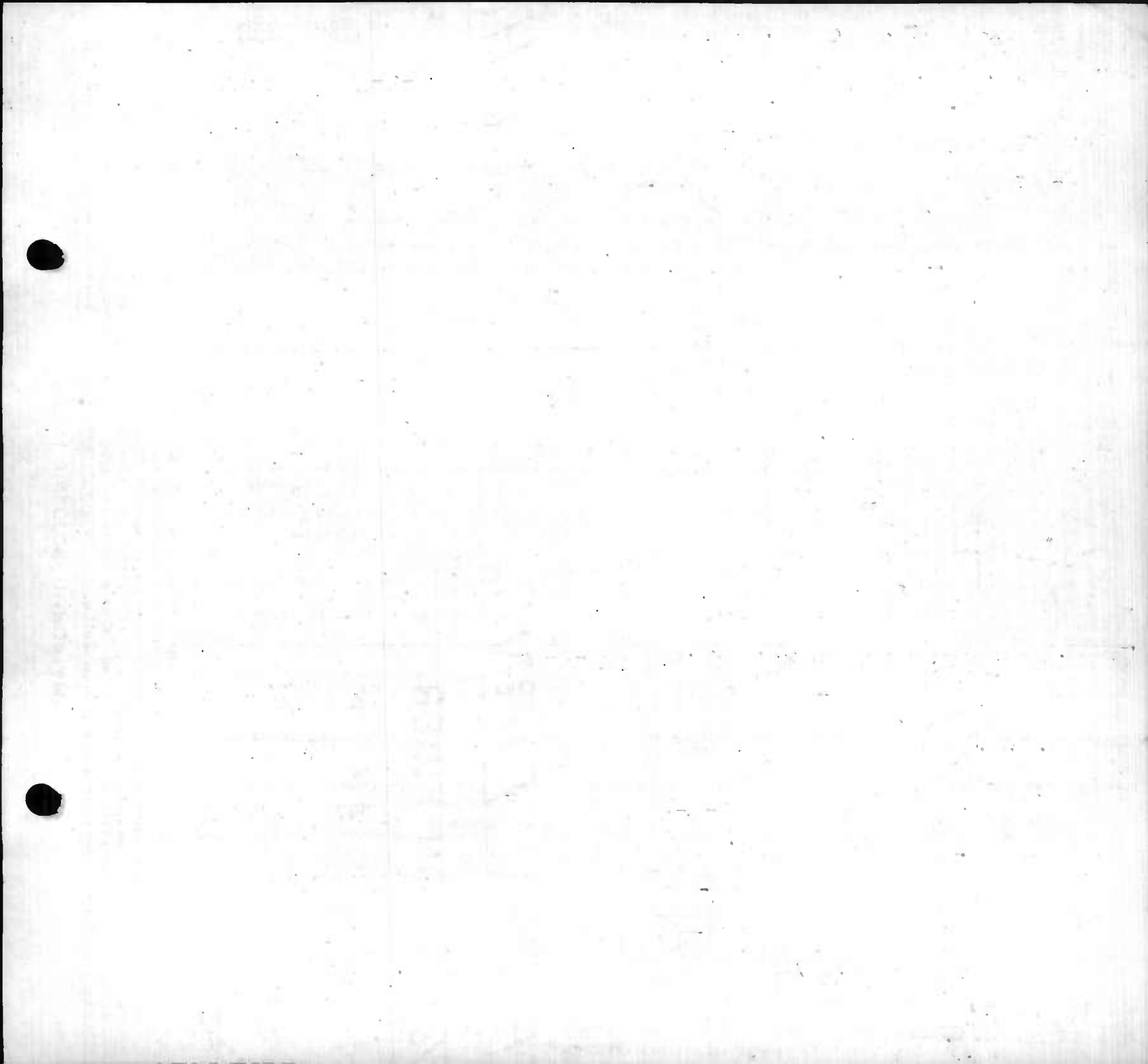
B-620 72 11833		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		72 11833	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>BOWERS TORI ELIZABETH.</b>		2. DATE AND HOUR OF DEATH <b>12/11/72 1:45 am.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Frederick</b>		STATE OF MARYLAND-DEMO	
FULL NAME OF HOSPITAL OR INSTITUTION <b>Univ. of Maryland Hosp</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>Frederick</b>	
				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>F.</b>		6. RACE <b>W.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>4/13/59</b>		9. AGE (In years last birthday) <b>13 years</b>		10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Frederick, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>GRAYSON R. BOWERS</b>		14. MOTHER'S MAIDEN NAME <b>Dorothy Zimmerman</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Grayson R. Bowers</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>Resp. Arrest - sec. to</b> <b>Pneumonia and ? Br. abuse.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <b>Cong. deformity, Mental retardation</b>		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Quadruplegia; Chorea</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12-3-72</b> 19 to <b>12-11-72</b> 19 that (I) (we) last saw the deceased alive on <b>12-10-72</b> 19 (midnight) and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>K. Merchant</b>		23B. DATE SIGNED <b>12-11-1972</b>			
23C. PHYSICIAN'S NAME (Type) <b>K. Merchant M.D.</b>		23D. ADDRESS <b>Resident in Pediatrics, Univ. of Md. Hosp.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-12-72</b>		24C. NAME of CEMETERY or CREMATORY <b>Mount Olivet Cemetery</b>	
24D. LOCATION <b>Frederick, Frederick, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 14 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Dailey &amp; Son</b>	
25C. FUNERAL DIRECTOR <b>Robert E. Dailey &amp; Son</b>		25D. ADDRESS <b>Frederick, Maryland</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>STATE OF MARYLAND-DEPT</u>	
72 11834				72 11834	
BIRTH NO.				M.	
1. NAME OF DECEASED (Type or Print) <u>Edith P. Kernan</u>			2. DATE AND HOUR OF DEATH <u>Dec. 10, 1972</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Caton Manor Nursing Home</u>			A. STATE <u>Maryland</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			B. COUNTY <u>1903</u>		
C. CITY OR TOWN <u>Baltimore</u>			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <u>432 S. Gilman Street</u>					
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-13-85</u>	9. AGE (In years - last birthday) <u>86</u>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>Charles Long</u>			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>218-05-6506</u>		
17. INFORMANT <u>Mrs. Gladys Probst</u>			ADDRESS <u>1201 Washington Blvd. 21230</u>		
18. <u>412.4 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <u>Arterio-Sclerotic - Cardio - Vascular disease</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10/28/72 to 12/10/72</u>		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Incarcerated Right Femoral hernia</u>			(B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Incarcerated Right Femoral hernia</u>					
19A. DATE OF OPERATION <u>01/02/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Incarcerated Right Femoral hernia</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>10/28/72</u> 19 to <u>12/10/72</u> 19, that (I) <del>was</del> last saw the deceased alive on <u>12/4/72</u> 19 and that (my) <del>own</del> applan death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>B. Martin Middleton M.D.</u>				23B. DATE SIGNED <u>12/10/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>B. Martin Middleton M.D.</u>				23D. ADDRESS <u>3350 W. Ikenes Ave Balto 26. md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-13-72</u>		24C. NAME of CEMETERY or CREMATORY <u>Loudon Park Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Frederick Ave. Balto. Maryland</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 14 1972</u>		25B. NAME OF REGISTRAR <u>Arlene Johnston</u>		25C. FUNERAL DIRECTOR <u>Thomas J. Kenny, Inc. 1600 Hollins Street</u>	



STATE OF MARYLAND - DEPT. OF HEALTH BALTIMORE CITY HEALTH DEPARTMENT									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH								REG. NO. 72 11835	
BIRTH NO. C-200 72 11835									
1. NAME OF DECEASED (Type or Print) M. Gertrude Cook					2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 12 9 72 8:40 A. M.				
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 2645 Miles Avenue					3. DATE PRONOUNCED DEAD Month Day Year Hour 12 9 72 8:40 A. M.				
6. SEX Female					5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1907				
7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
9. DATE OF BIRTH 3 - 24-1912		10. AGE (In years last birthday) 60		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		14B. KIND OF BUSINESS OR INDUSTRY		13. FATHER'S NAME Adolphus Johnson					
15. MOTHER'S MAIDEN NAME Alice (Unknown)				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, give year or dates of service) No					
17. SOCIAL SECURITY NO. 217-26-2295				18. INFORMANT ADDRESS Mr. James A. Cook, 2645 Miles Ave. 21211					
19. CAUSE OF DEATH									
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.									
(A) IMMEDIATE CAUSE Lobular pneumonia, right lung DUE TO, OR AS A CONSEQUENCE OF:									
(B) DUE TO, OR AS A CONSEQUENCE OF:									
(C)									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
20A. DATE OF OPERATION 2				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE EXAMINER'S NAME (Type) William P. Mulloy, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 12-9-72	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-12-1972		24C. NAME OF CEMETERY or CREMATORY Crest Lawn Cemetery			24D. LOCATION (City, town, or county) (State) Howard County, Maryland		
25A. DATE REC'D BY HEALTH DEPT. DEC 14 1972				25B. NAME OF REGISTRAR Sidney J. Weston		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229			

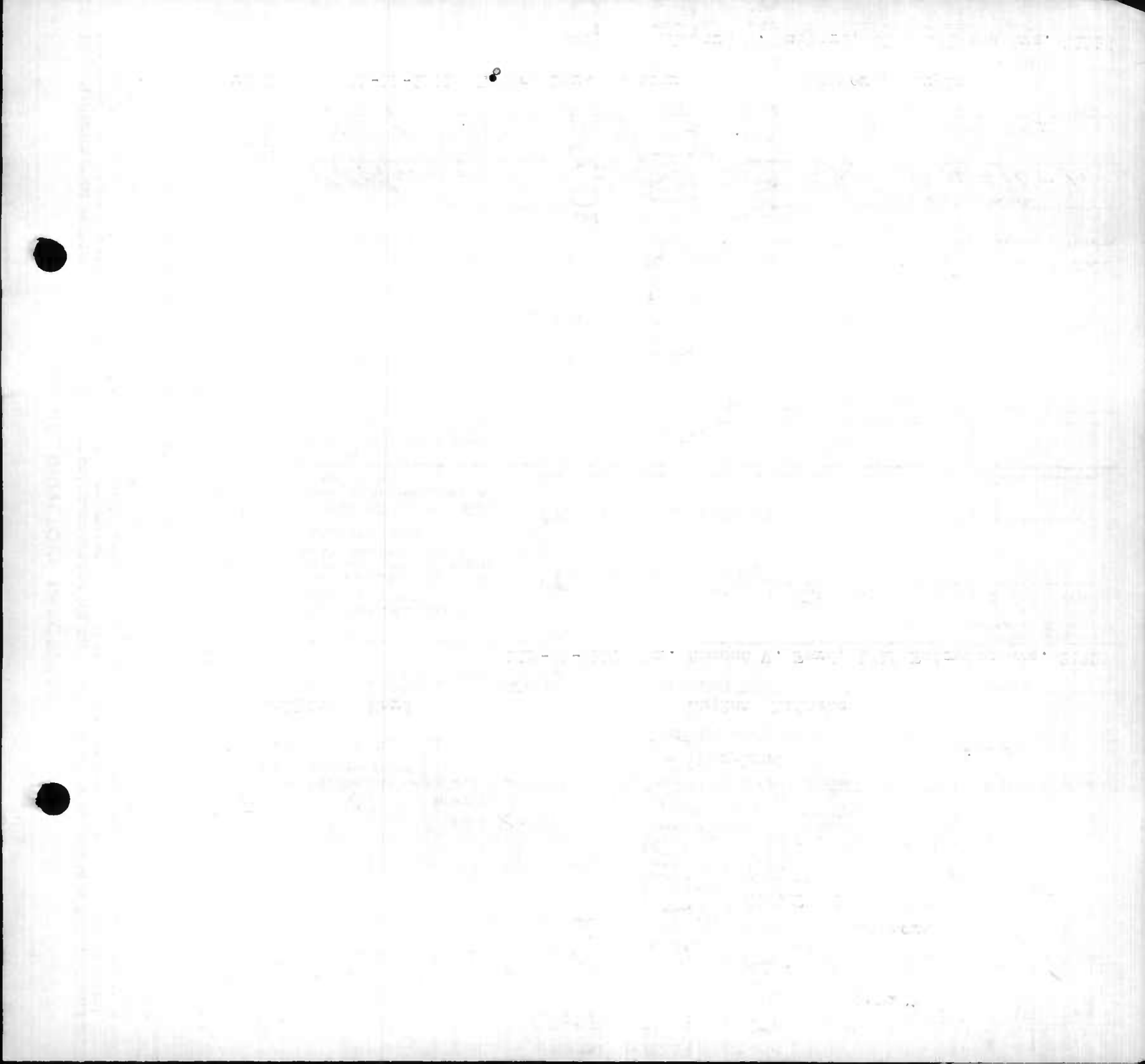
(1)  $\Rightarrow$

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

7-630		72 11836		BALTIMORE CITY HEALTH DEPARTMENT		72 11836	
BIRTH NO.				STATE OF MARYLAND-DEATH			
1. NAME OF DECEASED (Type or Print) <u>FORD Mrs. Margaret R.</u>				2. DATE AND HOUR OF DEATH <u>December 10, 1972 11:10 AM.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <u>Bon Secours Hospital</u> <u>34</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>HALETHORPE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>1815 Fairview Ave.</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/28/16</u>	9. AGE (In years last birthday) <u>55</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Ward</u>				14. MOTHER'S MAIDEN NAME <u>Regina Meineke</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-07-7333</u>		17. INFORMANT ADDRESS <u>Mr. Edmond V. Ford, 1815 Fairview Ave. 21227</u>			
18. I <u>62.1</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Ca of the Lung</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Ascites</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>12-6</u> 19 <u>72</u> to <u>12-10</u> 19 <u>72</u> that (I) (we) lost saw the deceased alive on <u>12-10</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>B. B. Aranas</u>				DEGREE Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>12-10-72</u>	
23C. PHYSICIAN'S NAME (Type) <u>DONIFACIO B. ARANAS MD.</u>				23D. ADDRESS <u>BON SECOURS HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-13-1972</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 14 1972</u>				25B. NAME OF REGISTRAR <u>Howard H. Hubbard</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u>	

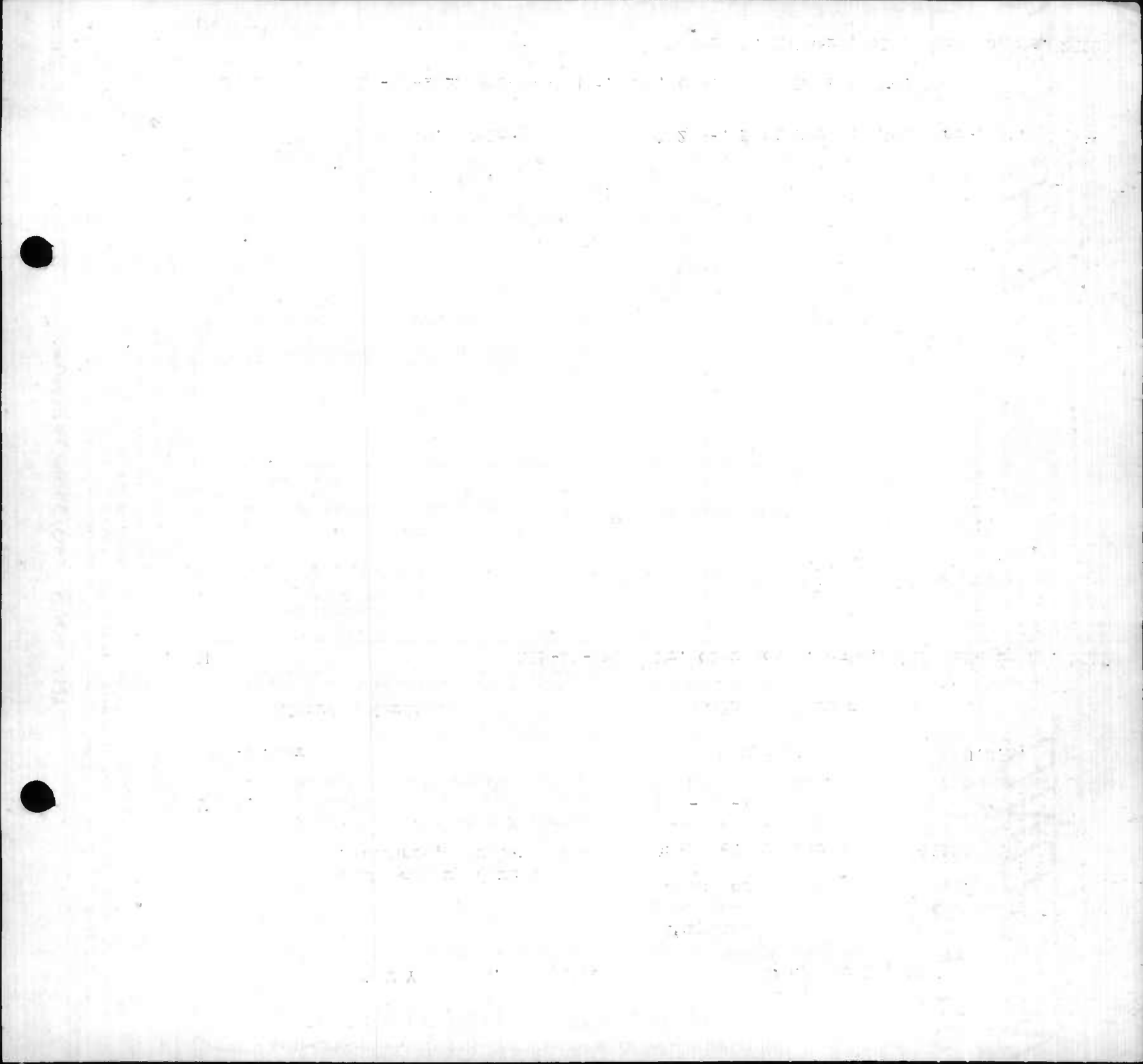




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
72 11837					REG. NO. 72 11837				
S-000					BIRTH NO.				
1. NAME OF DECEASED (Type or Print) <b>DOROTHY L. SHAW</b>					2. DATE AND HOUR OF DEATH <b>December 10, 1972</b>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>1815 McHenry Street Baltimore, Maryland 21223</b>					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1903</b>				
					C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
					E. STREET AND NUMBER <b>1815 McHenry Street 21223</b>				
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3 - 11-1924</b>	9. AGE (In years last birthday) <b>48</b>	10. UNDER 1 Yr. Months: Days: Hours: Min.		11. UNDER 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>				10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Edward Warfield</b>					14. MOTHER'S MAIDEN NAME <b>Beulah Morris</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>215-22-0679</b>		17. INFORMANT <b>Mr. Clarence E. Shaw, 1815 McHenry St. 21223</b>			
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>MYOCARDIAL INFARCTION</b> <b>ARTERIOSCLEROSIS; Right bundle br. block</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
II DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <b>1971</b> to <b>Nov. 1972</b> , that (II) (we) last saw the deceased alive on <b>11-28-1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Aidan E. Walsh</b>								23B. DATE SIGNED <b>12-11-72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Aidan E. Walsh</b>					23D. ADDRESS <b>222 St. Paul Street, Baltimore, Md. 21202</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-13-1972</b>		24C. NAME OF CEMETERY or CREMATORY <b>Maryland Nat. Mem. Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Laurel, Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 14 1972</b>			25B. NAME OF REGISTRAR <b>Sidney H. Houghton</b>			25C. FUNERAL DIRECTOR <b>Howard H. Hubbard</b>			25D. ADDRESS <b>4107 Wilkens Ave. 21229</b>



1

STATE OF MARYLAND - DEPT.

72 11838

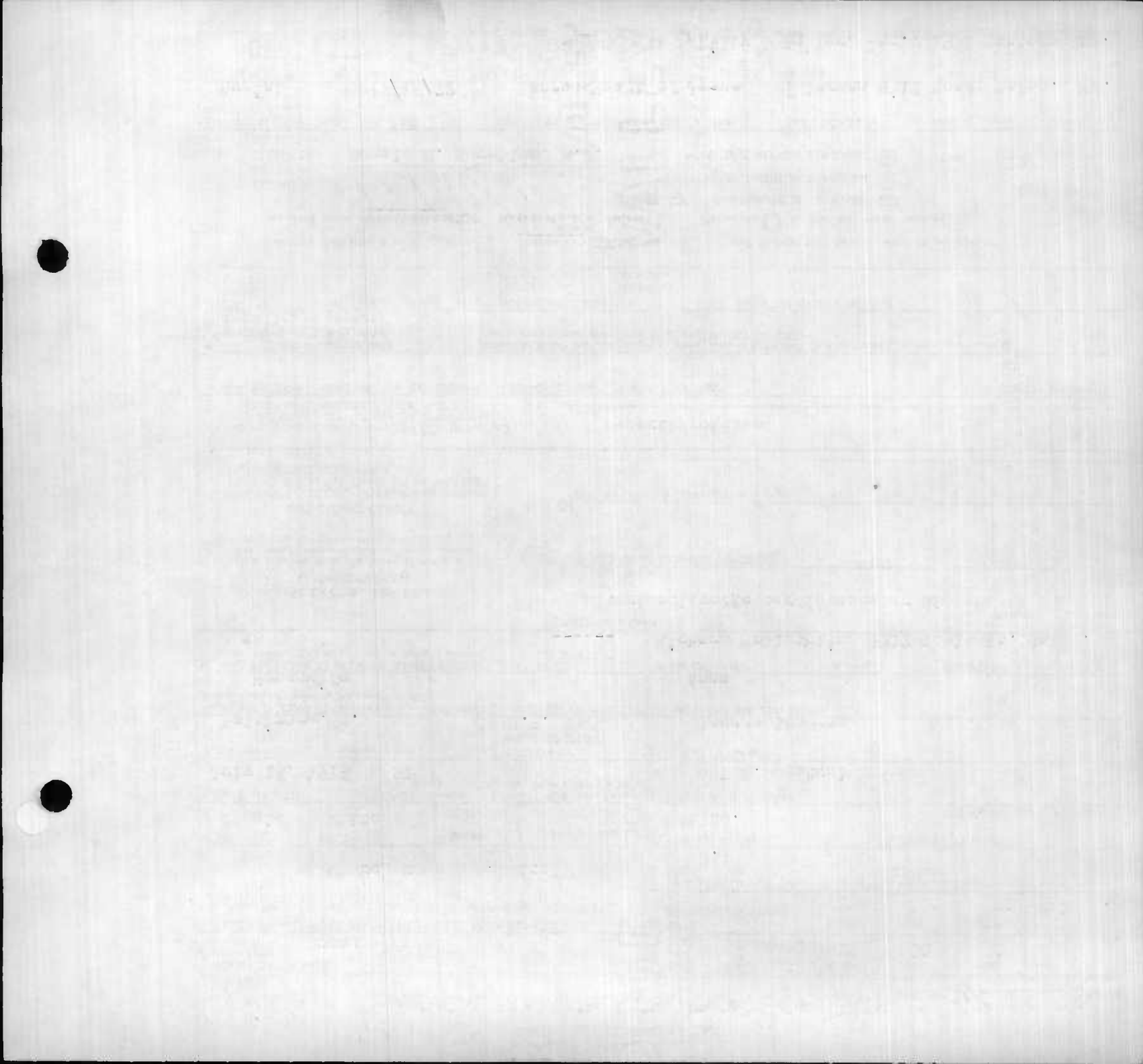
BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 11838

BIRTH NO.

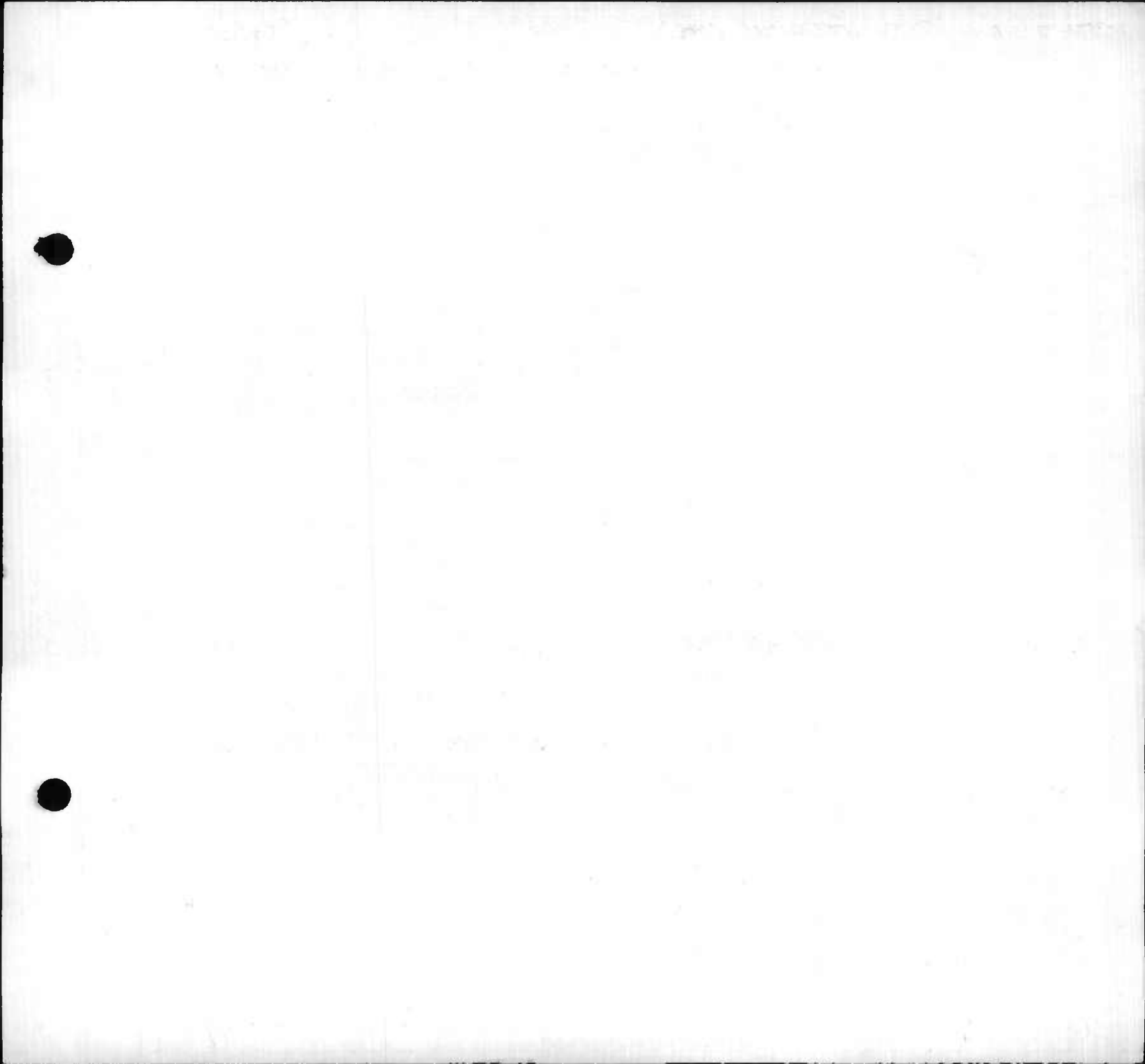
1. NAME OF DECEASED (Type or Print) <b>Frances Jaski</b>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month <b>12</b> Day <b>12</b> Year <b>72</b> Hour <b>M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>35 Church Home &amp; Hospital</b>				3. DATE PRONOUNCED DEAD Month <b>12</b> Day <b>12</b> Year <b>72</b> Hour <b>8:30 a.m.</b>	
6. SEX <b>female</b>		7. RACE <b>White</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>July 15, 1915</b>		10. AGE (In years lost birthday) <b>57</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>George Goodman</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
15. MOTHER'S MAIDEN NAME <b>Anna</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>-----</b>	
18. INFORMANT <b>Richard McGlothlin</b>		19. ADDRESS <b>3312 Noble St., Balto.</b>		20. CAUSE OF DEATH <b>Arteriosclerotic cardiovascular disease</b>	
21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Hyperthyroidism</b>		22. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
23. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		24. DATE OF OPERATION <b>12/15/72</b>		25. CONDITION FOR WHICH OPERATION WAS PERFORMED	
26. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		27. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		28. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
29. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		30. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		31. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ACTUAL SIGNATURE <i>Ronald N. Kornblum</i> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>12/12/72</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/15/72</b>		24C. NAME of CEMETERY or CREMATORY <b>Sacred Heart of Jesus</b>	
24D. LOCATION (City, town, or county) (State) <b>German Hill Road, Balto., Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 14 1972</b>		25B. NAME OF REGISTRAR <i>Andrew J. Kostomarov</i>	
25C. FUNERAL DIRECTOR <b>Lilly &amp; Zeller, Inc., 1901 Eastern Ave.</b>		25D. ADDRESS		25E. DATE	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

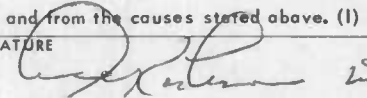
BALTIMORE CITY HEALTH DEPARTMENT				72 11839		REG. NO. 72 11839	
<b>P-626</b> BIRTH NO.				<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <b>WASIL PROKURAT</b>				2. DATE AND HOUR OF DEATH <b>DEC. 12, 1972 7:05 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>CHURCH HOME &amp; HOSPITAL</b> <b>35</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>SEVERN A A 5200</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>CHURCH HOME &amp; HOSPITAL</b> <b>35</b>				C. CITY OR TOWN <b>SEVERN</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>M</b> 6. RACE <b>W</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>APR 4 - 1894</b>		9. AGE (In years last birthday) <b>78</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DRY DOCK</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>MD. DRY DOCK</b>		11. BIRTHPLACE (State or foreign country) <b>POLAND</b>	
13. FATHER'S NAME <b>PECOFIL PROKURAT</b>				14. MOTHER'S MAIDEN NAME <b>SOPHIE (?)</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>212-074580</b>		17. INFORMANT <b>JEAN WALDREN</b>	
18. <b>15301</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <b>MULTIPLE LUNG METASTASES</b> DUE TO, OR AS A CONSEQUENCE OF: <b>CA OF THE COLON (CECUM)</b>			
(B) <b>CA OF THE COLON (CECUM)</b> DUE TO, OR AS A CONSEQUENCE OF:				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>RECURRENT CA, ABD. WALL</b>							
19A. DATE OF OPERATION <b>12/4/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>METASTATIC TUMOR</b>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>11-16</b> 19 <b>72</b> to <b>12-12</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>12-12</b> 19 <b>72</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>C. J. V. J. V.</b>				23B. DATE SIGNED <b>12/12/72</b>		23C. PHYSICIAN'S NAME (Type) <b>CEGAR P. J. V. J. V.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>				24B. DATE <b>12-15-72</b>		24C. NAME of CEMETERY or CREMATORY <b>HOLY ROSARY</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 14 1972</b>				25B. NAME OF REGISTRAR <b>DR. J. V. J. V.</b>		25C. FUNERAL DIRECTOR <b>JOHN M. WEBER &amp; SONS</b>	
24D. LOCATION (City, town, or county) (State) <b>PUNDALIK MD.</b>				25D. ADDRESS <b>401 S. CHESTER</b>			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 11840		72 11840	
CERTIFICATE OF DEATH				REG. NO.		STATE OF MARYLAND-DEM	
BIRTH NO. H-420		72 11840		2. DATE AND HOUR OF DEATH 12/12/72 6:25 P. M.			
1. NAME OF DECEASED (Type or Print) <b>Ludwick Helewicz, Ludwig</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>202</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>40 St. Agnes Hospital Baltimore, Md.</b>				C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>40 St. Agnes Hospital Baltimore, Md.</b>				E. STREET AND NUMBER <b>Caton Manor Nursing Home, Wilkens &amp; Caton Ave</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/22/86</b>	9. AGE (In years lost birthday) <b>86</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AMERICAN SMELTING</b>				11. BIRTHPLACE (State or foreign country) <b>POLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>JOSEPH HELEWICZ</b>				14. MOTHER'S MAIDEN NAME <b>MARY ANN ?</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>212-10-2109</b>		17. INFORMANT <b>FRANK O'BRIEN</b> ADDRESS <b>110 S WOLFE</b>	
18. <b>155.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Bleeding</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>1 Hepatitis</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Myocardial Bleeding</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>1 Hepatitis</b> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b> <b>2 yrs.</b>	
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). _____							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20A. AUTOPSY? (Yes or No) _____		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____			
22. I certify that (I) (this hospital) attended the deceased from <b>Nov 15 1972</b> to <b>Dec 12 1972</b> , that (I) (we) last saw the deceased alive on <b>Dec 11 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE 				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>12-13-72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. H.A. Kochman</b>				23D. ADDRESS <b>7945 Stevenson Rd - 21208</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12-16-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>HOLY ROSARY</b>		24D. LOCATION (City, town, or county) (State) <b>DUNDALK MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 14 1972</b>		25B. NAME OF REGISTRAR <b>Audrey Whitman</b>		25C. FUNERAL DIRECTOR <b>JOHN W. WEBER &amp; SONS INC.</b>		ADDRESS <b>4013 CHESTER ST.</b>	

8/31/72 - Adm.

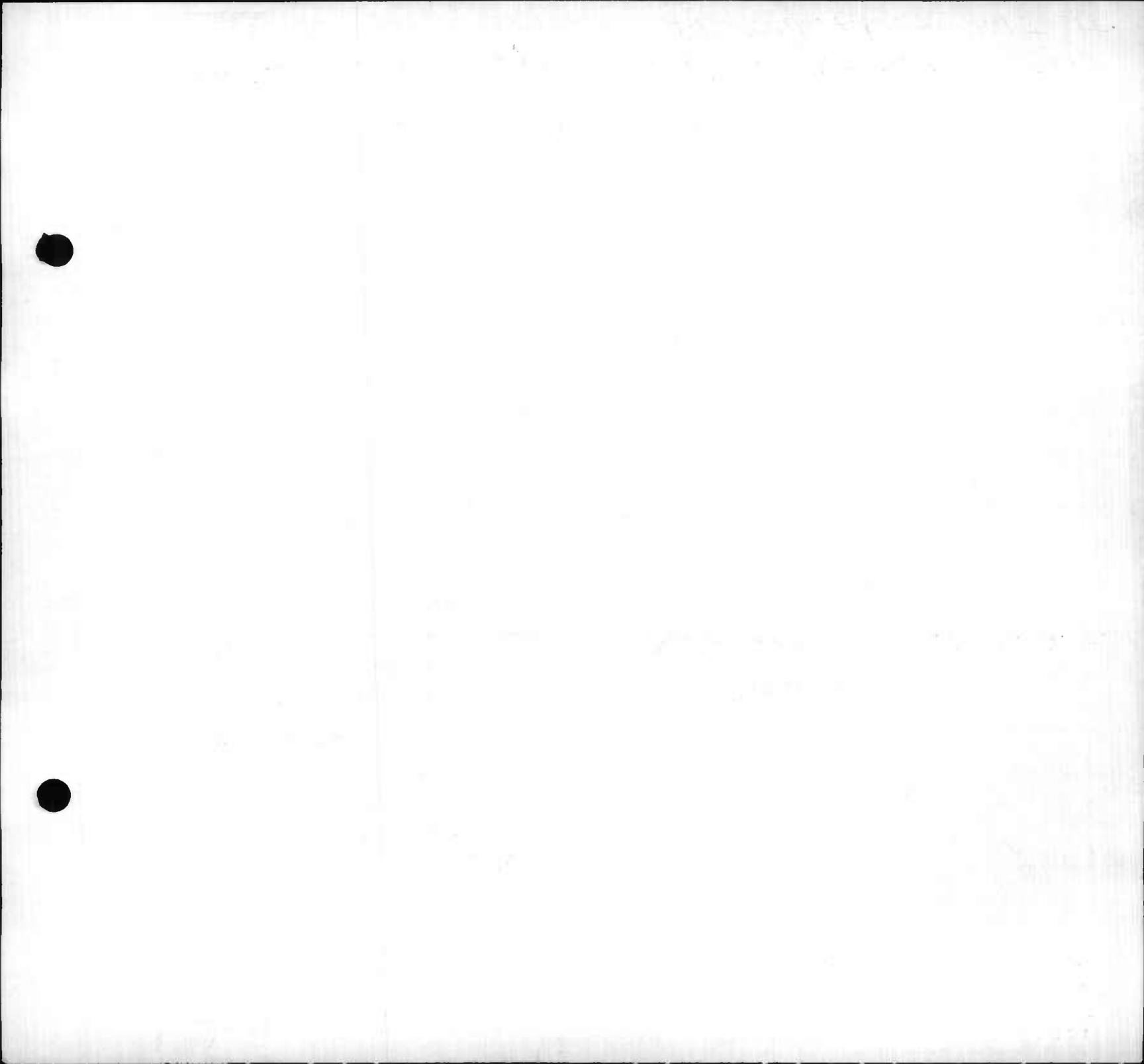
110 S. WOLFE 21131.

J

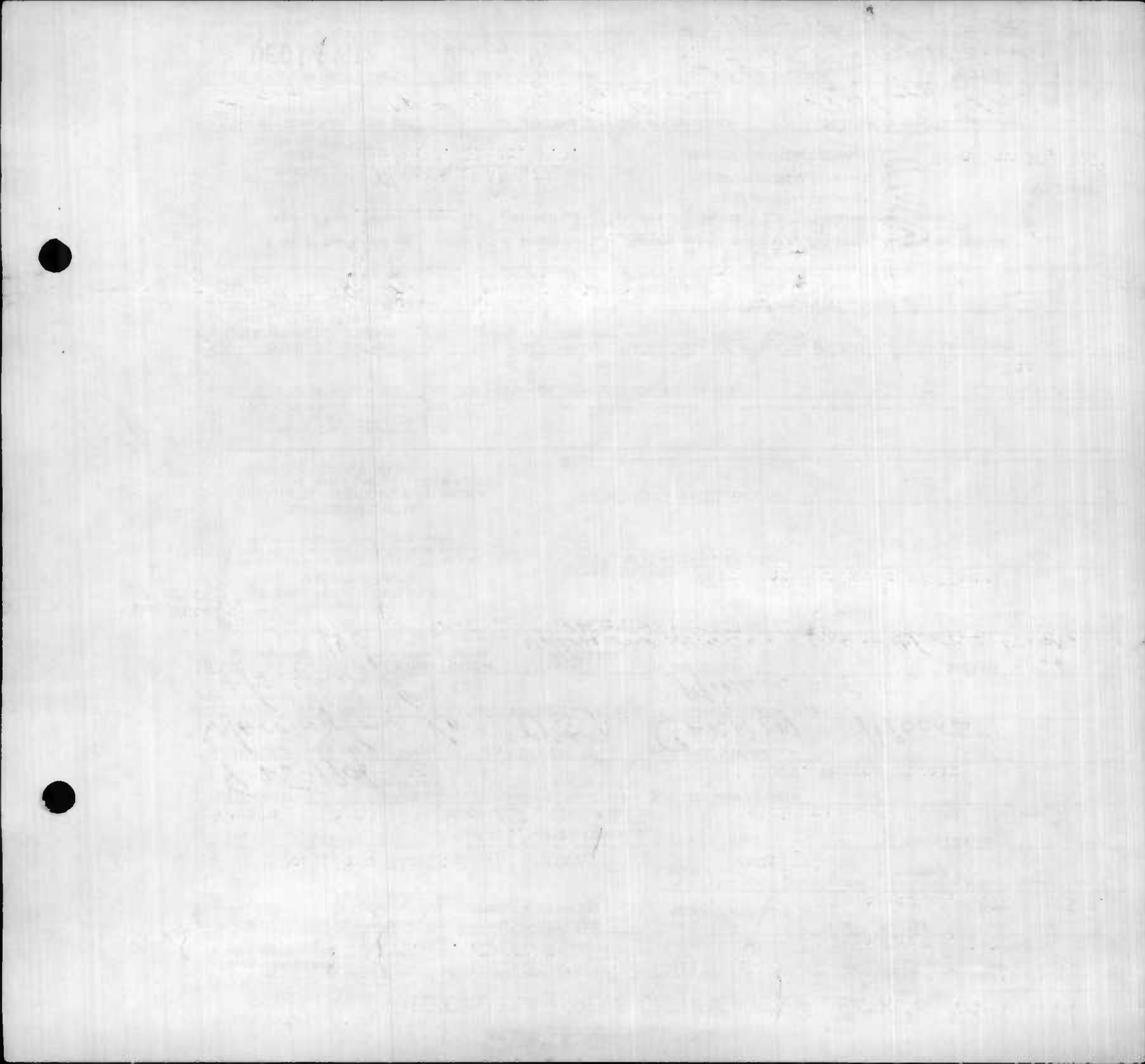
# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <span style="float: right;">72 11841</span>	
BIRTH NO. <span style="float: right;">D-400</span>		72 11841			
1. NAME OF DECEASED (Type or Print) <span style="float: right;">DUL MRS MARY</span>		2. DATE AND HOUR OF DEATH <span style="float: right;">12-13-1972</span> <span style="float: right;">12<sup>05</sup> AM</span>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <span style="float: right;">Maryland</span> B. COUNTY <span style="float: right;">602</span>			
FULL NAME OF HOSPITAL OR INSTITUTION <span style="float: right;">35 Church Home &amp; Hospital Baltimore MD.</span>		C. CITY OR TOWN <span style="float: right;">Baltimore</span>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <span style="float: right;">206 N. Port Street - 21224.</span>			
5. SEX <span style="float: right;">F.</span>	6. RACE <span style="float: right;">W.</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="float: right;">12-16-1893</span>	9. AGE (In years last birthday) <span style="float: right;">78.</span>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="float: right;">HOUSEWIFE</span>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="float: right;">POLAND</span>	
13. FATHER'S NAME <span style="float: right;">Wolk, Walter</span>		14. MOTHER'S MAIDEN NAME <span style="float: right;">UNKNOWN</span>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="float: right;">No</span>		16. SOCIAL SECURITY NO. <span style="float: right;">218-50-5134</span>		17. INFORMANT <span style="float: right;">STELLA TEBO</span> ADDRESS <span style="float: right;">3440 McDonald Rd. Va. BEA</span>	
18. <span style="float: right;">412.21</span> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <span style="float: right;">Cardiac &amp; Pulmonary arrest</span> DUE TO, OR AS A CONSEQUENCE OF: <span style="float: right;">Chronic renal failure</span>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <span style="float: right;">Hypertension</span> DUE TO, OR AS A CONSEQUENCE OF: <span style="float: right;">Arteriosclerotic Cardiovascular Disease</span>			
		(C) <span style="float: right;">Congestive Heart Failure</span>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <span style="float: right;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="float: right;">12/11/1972</span> to <span style="float: right;">12/13/1972</span> that (I) (we) last saw the deceased alive on <span style="float: right;">12/13/1972</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="float: right;">M. Yousuf Siddiqui M.D.</span>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <span style="float: right;">12/13/1972</span>	
23C. PHYSICIAN'S NAME (Type) <span style="float: right;">M. YOUSUF SIDDIQUI M.D.</span>		23D. ADDRESS <span style="float: right;">Church Home &amp; Hosp. 100 N. Broadway Baltimore MD - 21231.</span>			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE <span style="float: right;">12-15-72</span>	24C. NAME OF CEMETERY or CREMATORY <span style="float: right;">Holy Cross (Polish National) BALTIMORE, MD.</span>		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <span style="float: right;">DEC 14 1972</span>	25B. NAME OF REGISTRAR <span style="float: right;">Sidney Johnston</span>		25C. FUNERAL DIRECTOR <span style="float: right;">John M. Weber &amp; Sons 401 S. Chester St.</span> ADDRESS		



BIRTH NO.		72 11842		BALTIMORE CITY HEALTH DEPARTMENT		72 11842	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO.			
1. NAME OF DECEASED (Type or Print) <b>MARIE B. WILLIAMS</b>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> <b>November 29, 1972</b>		Month Day Year Hour	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Provident Hospital (DOA)</b>				3. DATE PRONOUNCED DEAD <b>November 29, 1972 8:25 P. M.</b>		Month Day Year Hour	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1504</b>							
6. SEX <b>Female</b>		7. RACE <b>Negro</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>8-25-1908</b>		10. AGE (in years last birthday) <b>64</b>		11. Under 1 Yr. 11 Under 24 Hrs. Months Days Hours		E. STREET AND NUMBER <b>2000 N. Monroe Street</b>	
11. BIRTHPLACE (State or foreign country) <b>Warrington, Va</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>CARRIN MOORE</b>			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME <b>Minnie ?</b>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>Unknown</b>		18. INFORMANT <b>Lambertine Williams</b>		ADDRESS <b>2000 Monroe St</b>	
19. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE <b>Fatty metamorphosis of liver</b> DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(C) DUE TO, OR AS A CONSEQUENCE OF:			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) <b>Yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Marvin S. Platt</b>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>November 30, 1972</b>	
EXAMINER'S NAME (Type)		<b>Marvin S. Platt, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-4-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary</b>		24D. LOCATION (City, town, or county) (State) <b>Brooklyn Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 14 1972</b>		25B. NAME OF REGISTRAR <b>Sidney Whitson</b>		25C. FUNERAL DIRECTOR <b>Carl Belmont Funeral Home</b>		ADDRESS <b>1827 W North Ave</b>	



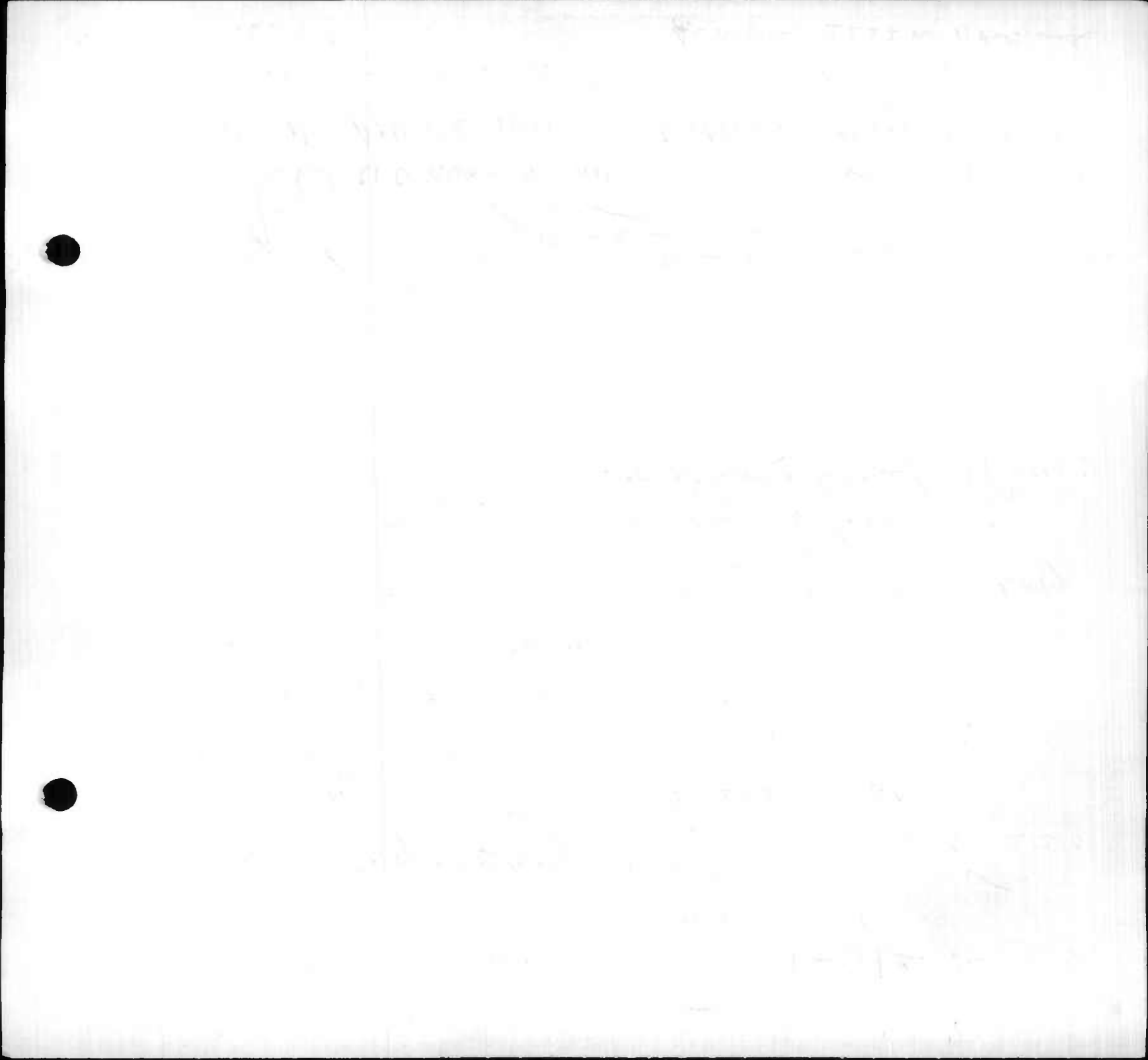


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 11843		REG. NO. 72 11843	
D-243				72 11843			
BIRTH NO.				STATE OF MARYLAND-DEM			
1. NAME OF DECEASED (Type or Print) <b>JOHN E. DESHIELDS Jr</b>				2. DATE AND HOUR OF DEATH <b>12-12-72 12:30p M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Lutheran Hospital of Maryland</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1606</b>			
				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>938 Franklinton Rd. 21216</b>			
5. SEX <b>M</b>	6. RACE <b>N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-12-11</b>	9. AGE (In years last birthday) <b>61</b>	If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tractor Operator</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Beth Steel</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore Md</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>John E. Deshields Sr</b>				14. MOTHER'S MAIDEN NAME <b>Ball Reason</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>2-17-01-8788</b>		17. INFORMANT <b>Mrs Gaskell Deshields</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Gastrointestinal hemorrhage</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
				(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Esophageal &amp; V. Diseases</b>			
				(C) <b>Alcoholic Cirrhosis</b>		Duration Unknown	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20A. AUTOPSY? (Yes or No) <b>no</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <b>—</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>—</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>—</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>—</b>			
22. I certify that (I) (this hospital) attended the deceased from <b>12-12-1972</b> to <b>12-12-1972</b> and that (I) (we) last saw the deceased alive on <b>12-12-1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>[Signature]</b>				23B. DATE SIGNED <b>12-12-72</b>			
23C. PHYSICIAN'S NAME (Type) <b>M. H. ANWAR MD</b>				23D. ADDRESS <b>Lutheran Hospital of Maryland</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Buried</b>		24B. DATE <b>12-15-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Trinity Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 14 1972</b>		25B. NAME OF REGISTRAR <b>[Signature]</b>		25C. FUNERAL DIRECTOR <b>[Signature]</b>		ADDRESS <b>2222 W. North Ave</b>	

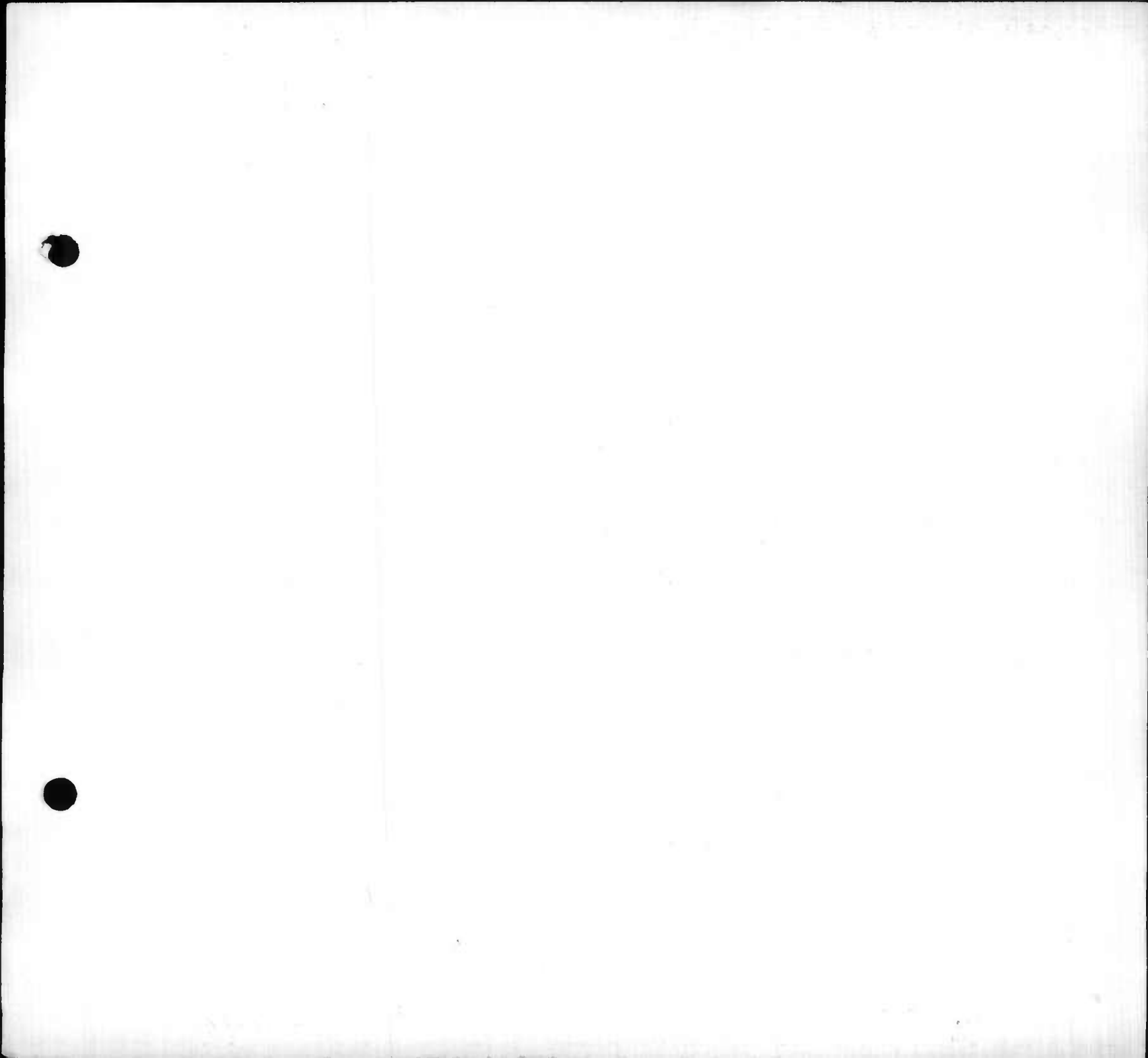




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 11844	
W-300				72 11844	
BIRTH NO.				72 11844	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH	
Mrs. Maggie Wood				12/11/72 7:50 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
Bon Secours Hospital				Maryland 2001	
C. CITY OR TOWN				D. INSIDE CITY LIMITS?	
Baltimore				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER				1941 W. Fayette St.	
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
Female		Black		WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH		9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
6-6-19		52		Housewife	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
North Carolina		U.S.A.		James Fenner	
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
Maggie Gunther		No		2 720-6671	
17. INFORMANT		18. CAUSE OF DEATH		19. MEDICAL CERTIFICATION	
Mr. James Wood		Hollywood Cal. 1134 Sycamore Ave		I	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		Hepatic Coma		days	
ANTECEDENT CAUSES		(B) Portal cirrhosis of the liver		years	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)		II	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Pseudomembranous colitis		days	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		Yes	
21D. TIME OF INJURY (APPROX.)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
(Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Nov. 25 1972 to Dec 11 1972		White At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		that (I) (we) last saw the deceased alive on Dec. 11 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
A. Nahon, MD		12-11-72		ABED LABERI-GHOUGHARI MD	
23D. ADDRESS		24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
Bon Secours Hospital		Burial		12-13-72	
24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT.	
Holiflex Cem		Holiflex N.C.		DEC 14 1972	
25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		25D. ADDRESS	
J. J. J. J. J.		J. J. J. J. J.		2222 W. North Ave	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-260 72 11845				BALTIMORE CITY HEALTH DEPARTMENT		72 11845	
BIRTH NO.				REG. NO.		STATE OF MARYLAND DEPT.	
1. NAME OF DECEASED (Type or Print) <b>BAKER JOSEPH W.</b>				2. DATE AND HOUR OF DEATH <b>12/11/72 1:55 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>907</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>THE JOHNS HOPKINS HOSPITAL</b> <b>33</b>				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>1750 CARSWELL ST.</b>							
5. SEX <b>M.</b>	6. RACE <b>BLACK</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-3-14</b>	9. AGE (In years last birthday) <b>58</b>	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Va</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>BAKER, JOSEPH</b>				14. MOTHER'S MAIDEN NAME <b>WILLIAMS, ROSE</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>220 09 8730</b>		17. INFORMANT <b>Family</b>		ADDRESS	
18. <b>162.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>DISSEMINATED CANCER OF THE LUNG</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>MONTHS</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ATELECTASIS @ MIDDLE LOBE WEEKS</b> <b>PNEUMONIA</b> <b>DAYS</b>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>11/16/72</b> <b>11/27/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>METAST. TO BRAIN</b> <b>METAST. TO MEDIASTINAL NODES</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>NO AUTOPSY</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <b>NONE</b>		21C. WHERE DID INJURY OCCUR? <b>NO INJURY</b>		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) <b>NO INJURY</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> <b>NONE</b>		21F. HOW DID INJURY OCCUR? <b>NONE</b>			
22. I certify that (1) (this hospital) attended the deceased from <b>NOV 28</b> 19 <b>72</b> to <b>DEC. 11</b> 19 <b>72</b> , that (2) (we) last saw the deceased alive on <b>DEC. 11</b> , 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Geoffrey M Graeber, MD</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>DEC. 11, 1972</b>	
23C. PHYSICIAN'S NAME (Type) <b>GEOFFREY M. GRAEBER M.D.</b>				23D. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Dec 16</b>		24B. DATE <b>1972</b>		24C. NAME OF CEMETERY or CREMATORY <b>Anteburial Memorial Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 14 1972</b>		25B. NAME OF REGISTRAR <b>William Williams</b>		25C. FUNERAL DIRECTOR <b>William Williams</b>		ADDRESS <b>1701 N. Bond St. Md</b>	

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY

NO. 1000

NO. 1000

NO. 1000

NO. 1000

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY

NO. 1000

NO. 1000

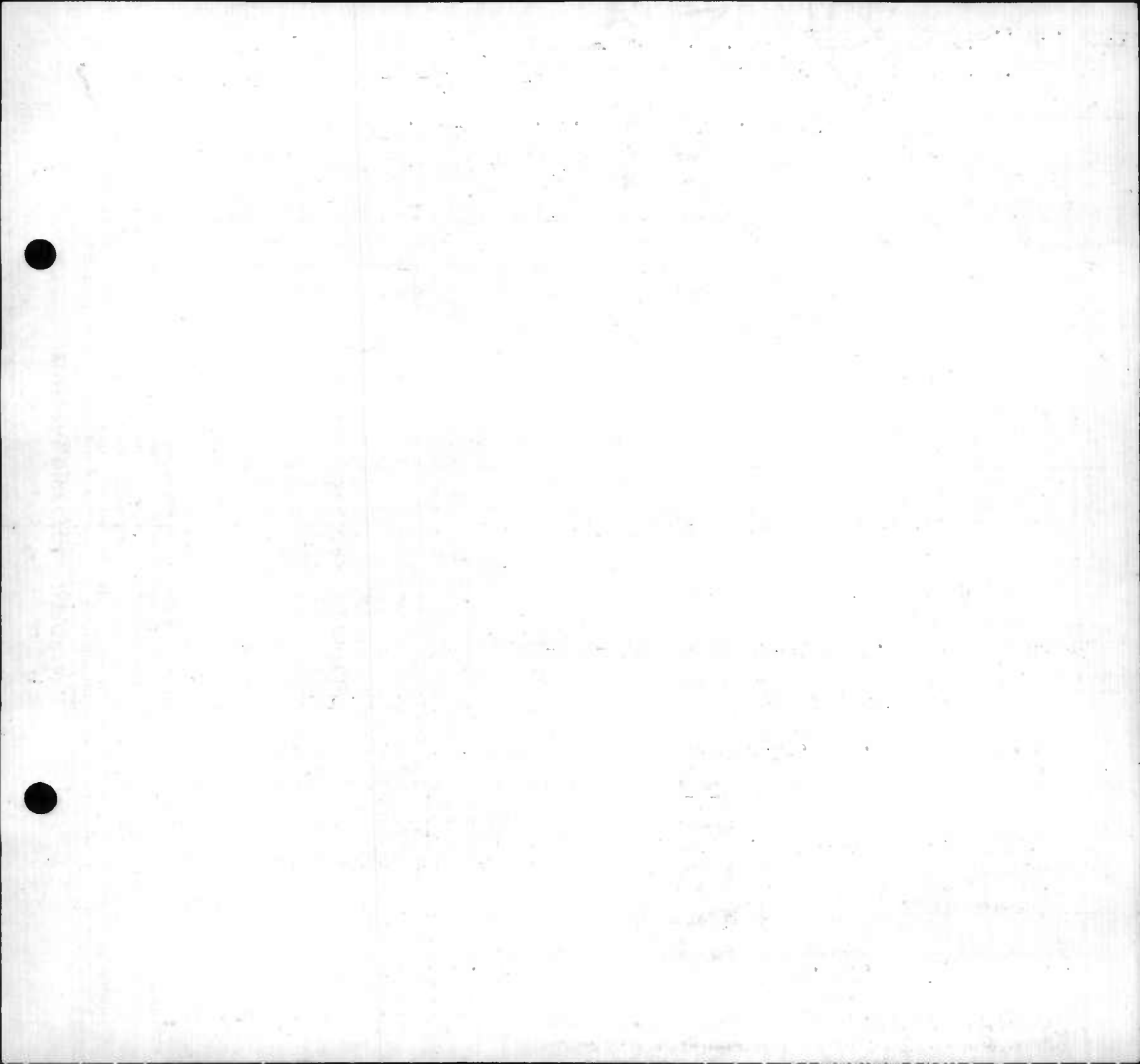
RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY

NO. 1000

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 11846		72 11846	
CERTIFICATE OF DEATH				STATE OF MARYLAND-DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Clara M. Dorsey				Dec. 13, 1972 2 p. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
90 Long Green Nursing Home				Maryland 1202			
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				3027 N. Calvert Street 21218			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
F	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8-5-1893	79			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife		Own Home		New Castle, Va.		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Paul Ripley				Mary Virginia Deisher			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No		220-547-410		Miss Virginia F. Dorsey		Same	
18. 4379 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral Arteriosclerosis 6 months			
ANTECEDENT CAUSES				(B) GENERALIZED ARTERIOSCLEROSIS			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) _____			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from OCT 12 1960 to DEC 13 1972, that (I) (we) last saw the deceased alive on DEC 12 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
John M. Scott, M.D.				12/14/72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
John M. Scott M. D.				600 W. Northern Parkway			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		12-16-72		Fort Lincoln		Washington, D. C.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
DEC 14 1972		A. W. Jenkins & Sons Co.		4905 York Road Balto., Md.		21218	

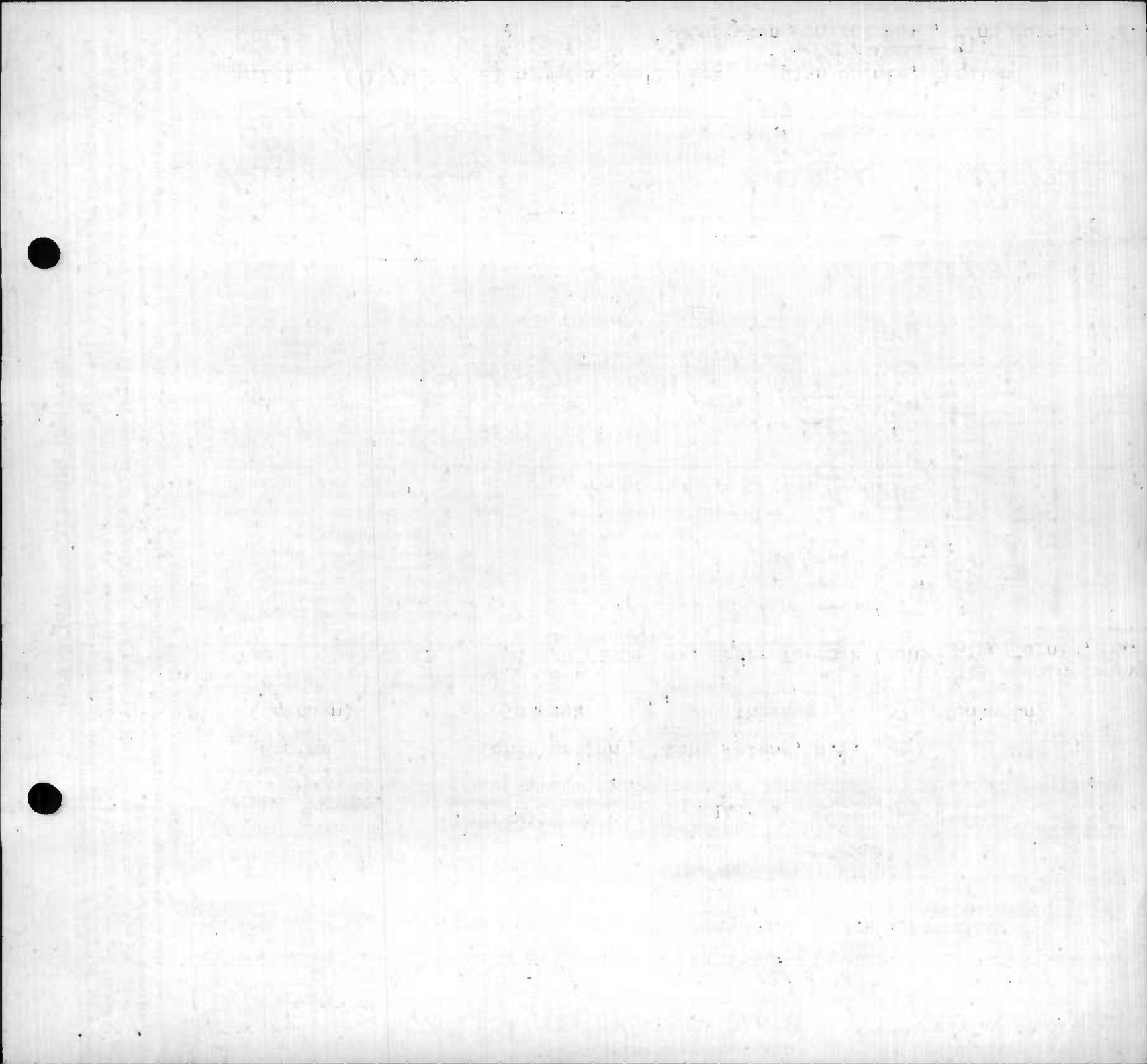




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 11847	
T-622				72 11847	
BIRTH NO. 7-610				REG. NO. 72 11847	
1. NAME OF DECEASED (Type or Print) <b>TURCZYK, Joseph J</b>			2. DATE AND HOUR OF DEATH <b>12/13/72 9:20 A</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>Johns Hopkins Hospital</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Anne Arundle</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Johns Hopkins Hospital</b>			C. CITY OR TOWN <b>Glen Burnie</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
E. STREET AND NUMBER <b>131 Thomas Road</b>					
5. SEX <b>Male</b>	6. RACE <b>Cauc.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/14/18</b>	9. AGE (In years last birthday) <b>53</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Roofer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Long Island, N.Y.</b>	
13. FATHER'S NAME <b>(unknown)</b>		14. MOTHER'S MAIDEN NAME <b>Theresa</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>132/03/6509</b>		17. INFORMANT <b>Mr. Starr Turczyk (son)</b>	
				ADDRESS <b>718 Washington Ave Glen Burnie, Md.</b>	
18. <b>430.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Intracranial Hemorrhage</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Intracranial Aneurysm of</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Anterior Cerebral Artery</b>			(B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>12/12</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Hydrocephalus - Blood in Ventricle</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <input type="checkbox"/>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <input type="checkbox"/>	
22. I certify that (I) (this hospital) attended the deceased from <b>12/12</b> 19 <b>72</b> to <b>12/13</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>12/13</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Harry R. Jacobson</b>				23B. DATE SIGNED <b>12/13/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Harry R. Jacobson</b>				23D. ADDRESS <b>The Johns Hopkins Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/16/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem'l Park</b>	
24D. LOCATION <b>Glen Burnie, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 14 1972</b>			
25B. NAME OF REGISTRAR <b>Harry R. Jacobson</b>		25C. FUNERAL DIRECTOR <b>Singleton Funeral Home, Glen Burnie, Md.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

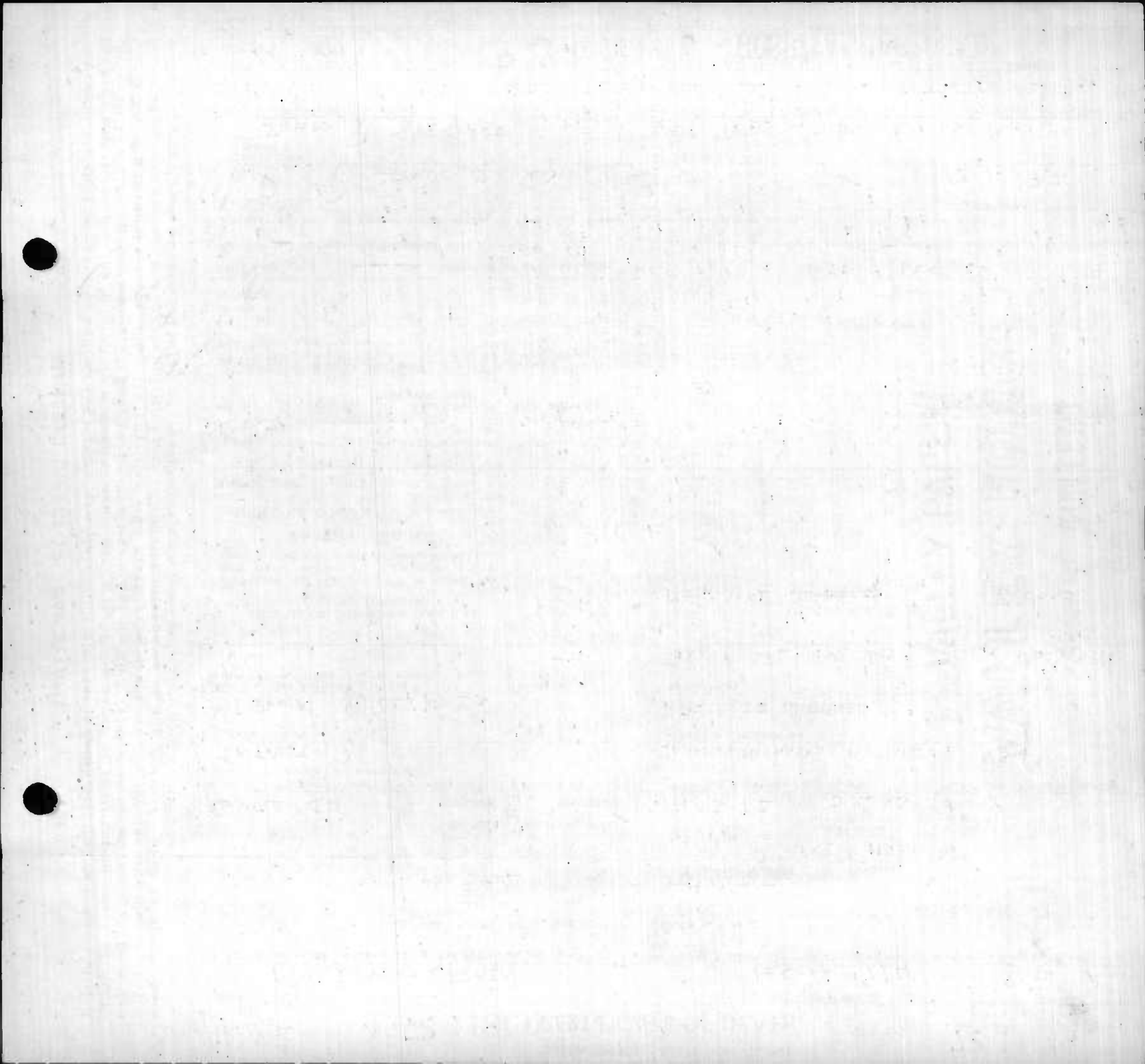
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 11848</u>	
BIRTH NO. <u>D-620</u>				72 11848	
1. NAME OF DECEASED (Type or Print) <u>DORSEY, MICHAEL FRANCIS</u>				2. DATE AND HOUR OF DEATH <u>DECEMBER 12, 1972 7:55 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. AGNES HOSPITAL</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>WILKENS &amp; CATON AVENUE</u> <u>BALTIMORE, MARYLAND 21229</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2582</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>1928 DEERING AVENUE</u> <u>21230</u>	
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>03-08-84</u>		9. AGE (In years last birthday) <u>88</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SANITATION WORKER</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Sanitation</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>JOHN DORSEY</u>		
14. MOTHER'S MAIDEN NAME <u>MARY ?</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		
16. SOCIAL SECURITY NO. <u>214124245</u>			17. INFORMANT <u>ST. AGNES HOSPITAL, WILKENS &amp; CATON AVE. BALTO, MD 21229</u>		
18. <u>1990</u> I CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Renal Failure days</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Carcinomatosis mos.</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <u>0</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) <u>NO</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Net While <input type="checkbox"/> At Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>DECEMBER 06</u> 19 <u>72</u> to <u>DECEMBER 12</u> 19 <u>72</u> , that (I) (we) last saw the deceased alive on <u>DECEMBER 12</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>C.R. Chaney M.D.</u> DEGREE				23B. DATE SIGNED <u>12/12/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>C.R. CHANEY, M.D.</u> DEGREE				23D. ADDRESS <u>ST. AGNES HOSPITAL, WILKENS &amp; CATON AVE. BALTO MD 21229</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>12/15/72</u>	24C. NAME OF CEMETERY or CREMATORY <u>Oaklawn Cem.</u>		24D. LOCATION <u>Baltimore Co. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 14 1972</u>		25B. NAME OF REGISTRAR <u>John J. Cowan Jr. &amp; Son Inc.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>901 Hollins St. 21225</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-452		72 11849		CITY HEALTH DEPARTMENT		REG. NO. 72 11849	
BIRTH NO. 72-16673		CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) <b>MULLINIX - CORBIN</b>				2. DATE AND HOUR OF DEATH <b>DEC. 12 1972 8:00 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>JOHNS HOPKINS HOSPITAL 33</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>P.G.</b> C. CITY OR TOWN <b>LAUREL</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>11698 PUMPKIN HILL DR.</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>CAU.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11.03.72</b>	9. AGE (In years last birthday) <b>5 WKS.</b>	10. Under 1 Yr. Months: <b>1</b> Days: <b>8</b>	11. Under 24 Hrs. Hours: <b>8</b> Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INFANT</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>JOHNS HOPKINS HOSPITAL</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>STEVEN MULLINIX</b>				14. MOTHER'S MAIDEN NAME <b>Barbara Sheehan</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>John P. STEWART MD.</b>		ADDRESS <b>Johns Hopkins Hosp.</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>NEONATAL Meningitis</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>E. Coli Sepsis</b>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>NEONATAL Meningitis</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>E. Coli Sepsis</b> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Bleeding from eroded gastrostomy</b>							
19A. DATE OF OPERATION <b>12</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>DEC. 04 1972</b> to <b>DEC. 12 1972</b> , that (I) ( <del>was</del> ) last saw the deceased alive on <b>DEC. 12 1972</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>Was</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.							
23A. SIGNATURE <b>John P. Stewart MD</b>				23B. DATE SIGNED <b>12/12/72</b>			
23C. PHYSICIAN'S NAME (Type) <b>JOHN P. STEWART MD</b>				23D. ADDRESS <b>DEPT. PEDS. JOHNS HOPKINS HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Crementation</b>		24B. DATE <b>12/12/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Johns Hopkins Hospital</b>		24D. LOCATION (City, town, or county) (State) <b>601 N. Broadway Balto., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 14 1972</b>		25B. NAME OF REGISTRAR <b>Adolphus...</b>		25C. FUNERAL DIRECTOR <b>68 HOSPITAL DISPOSAL</b>		ADDRESS	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-000		72 11850		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 72 11850	
BIRTH NO.		CERTIFICATE OF DEATH				STATE OF MARYLAND-DEATH			
1. NAME OF DECEASED (Type or Print) Willis A. Ray, Sr		2. DATE AND HOUR OF DEATH Dec. 12, 1972 1 15 P. M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. Anne Arundel 5200 B. COUNTY				C. CITY OR TOWN Severn			
FULL NAME OF HOSPITAL OR INSTITUTION South Baltimore Gen. Hosp 3001 S. Hanover St.		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX M		6. RACE Cauc.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-8-91		9. AGE (in years last birthday) 81	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mail Carrier		10B. KIND OF BUSINESS OR INDUSTRY Ret. - US Post Office		11. BIRTHPLACE (State or foreign country) Md.				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William A. Ray				14. MOTHER'S MAIDEN NAME Rachel Gardner					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-76-7880A		17. INFORMANT William E. Ray				ADDRESS	
18. 25041		CAUSE OF DEATH						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CONGESTIVE HEART FAILURE ARTERIOLO NEPHRO SCLEROSIS ARTERIO SCLEROTIC HEART DISEASE (B) DUE TO, OR AS A CONSEQUENCE OF: DIABETES MELLITUS (C) GENERALISED ARTERIO SCLEROSIS						24 Hrs. Many yrs. 50 years 50 years 50 years	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). ACUTE BRONCHOPNEUMONIA						1 week	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from Sept 4 1968 to Dec 12 1972 that (I) (we) last saw the deceased alive on Dec 12 1972 and that I (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Colvin C. Carter, M.D.				23B. DATE SIGNED Dec 12, 1972				23C. PHYSICIAN'S NAME (Type) Colvin C. Carter, M.D.	
23D. ADDRESS 3001 S. Hanover St.				24A. BURIAL CREMATION, REMOVAL (Specify) Burial					
24B. DATE 15 Dec. 72		24C. NAME OF CEMETERY or CREMATORY Friendship Cemetery		24D. LOCATION Linthicum, AA Co., Md.		25A. DATE REC'D BY HEALTH DEPT. DEC 14 1972			
25B. NAME OF REGISTRAR Sidney Johnson		25C. FUNERAL DIRECTOR Wirkley Funeral Home, Glen Burnie, Md.		25D. ADDRESS					



1951

12 6 AC

1950 1 6

1951 1 6

1950 1 6

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 11851

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>GEORGE DRAGO</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>43 SOUTH BALTO. GENERAL HOSPITAL</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>December 11, 1972</b> Hour <b>11:55 P.</b>	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2534</b>	
9. DATE OF BIRTH <b>14 Dec. 1904</b>		10. AGE (In years last birthday) <b>68</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sign Painter</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>Mrs. George Drago</b>		ADDRESS <b>21225 Herndon Court, Balto.</b>	

19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Fatty metamorphosis of liver</b>		

20A. DATE OF OPERATION <b>22</b>	20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	21. AUTOPSY? (Yes or No) <b>yes</b>
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	22F. HOW DID INJURY OCCUR?

23. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

Deputy CHIEF MEDICAL EXAMINER ☒  
ASSISTANT MEDICAL EXAMINER ☐  
ASSOCIATE MEDICAL EXAMINER ☐

ACTUAL SIGNATURE **Ronald N. Kornblum** M.D.  
EXAMINER'S NAME (Type) **Ronald N. Kornblum, M.D.**

DATE SIGNED **12/12/72**

24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>15 Dec. 72</b>	24C. NAME OF CEMETERY or CREMATORY <b>Glen Haven Memorial Park</b>	24D. LOCATION (City, town, or county) (State) <b>Glen Burnie, AA, Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 14 1972</b>	25B. NAME OF REGISTRAR <b>Sidney W. Kornblum</b>	25C. FUNERAL DIRECTOR ADDRESS <b>Kirkley Funeral Home, Glen Burnie, Md.</b>	

J. C. AS

10

J. J. FULCINI.

1950. 10. 15

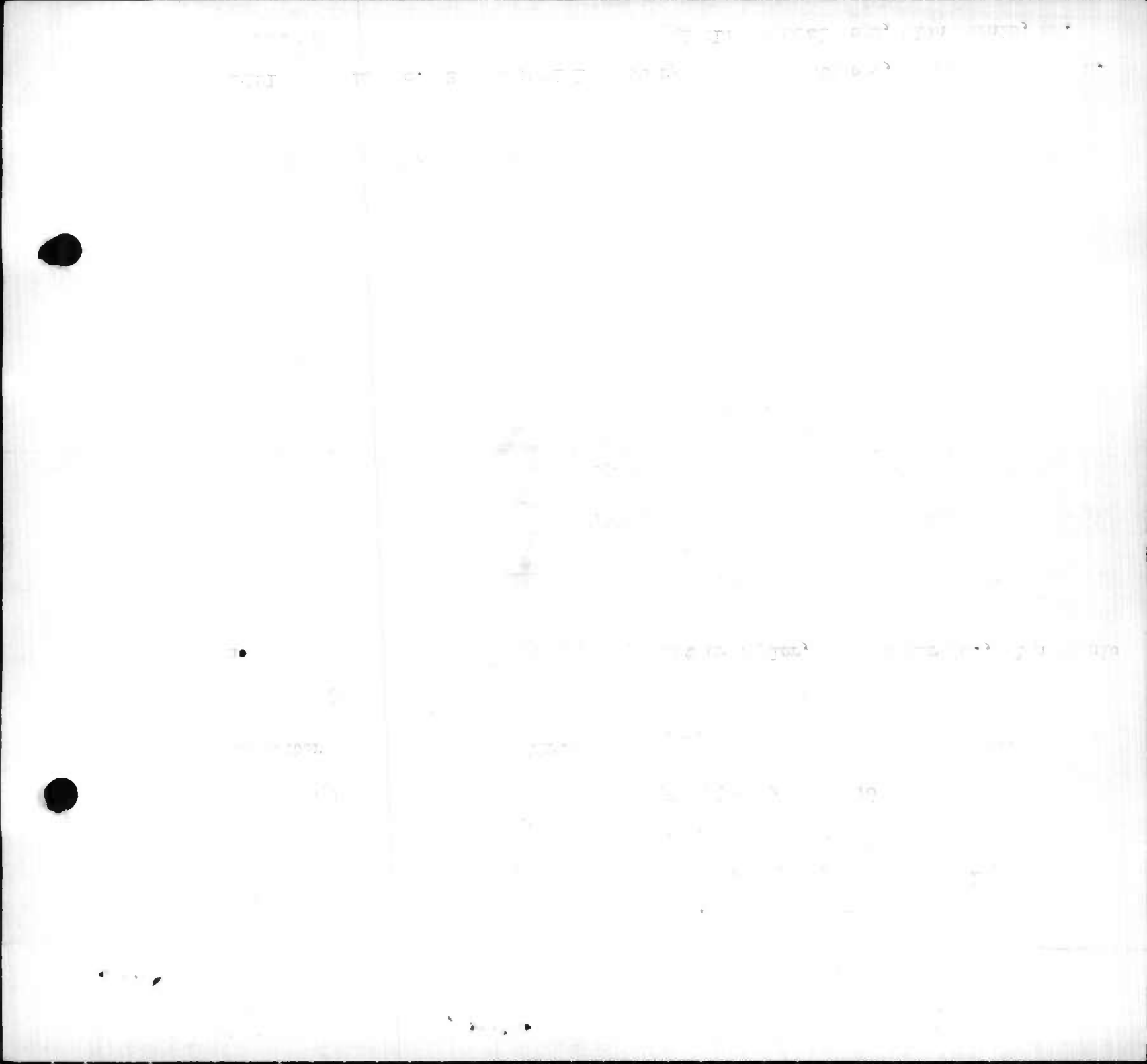
91 XIII

X

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 11852	
P-362 72 11852				CERTIFICATE OF DEATH	
BIRTH NO.				STATE OF MARYLAND - DISTRICT	
1. NAME OF DECEASED (Type or Print) <u>PETERS, HARVEY</u>			2. DATE AND HOUR OF DEATH <u>12-13-72 8:50 AM</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>GOOD SAMARITAN HOSPITAL</u>			A. STATE <u>MD.</u> B. COUNTY <u>AA</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>Glen Burnie</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>male</u> 6. RACE <u>W</u>			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-17-96</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		9. AGE (In years last birthday) <u>76</u>
13. FATHER'S NAME <u>UNKNOWN</u>			14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		11. BIRTHPLACE (State or foreign country) <u>VA.</u>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>312-10 1159</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
17. INFORMANT <u>Arthur Taylor,</u>			ADDRESS <u>Wimmer Rd., Glen Burnie</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Pneumococcal Pneumonia</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <u>Mechanical RESPIRATOR</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Failure of</u> <u>RESPIRATION</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>(d) PNEUMOCOCAL PNEUMONIA</u> <u>(e) Diabetes mellitus</u>			(B) <u>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF: <u>(C) (R) sided rib frac 8" tall</u>		
19A. DATE OF OPERATION <u>None</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>None</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>609 Crain Highway</u>	
21D. TIME OF INJURY (APPROX.) <u>12-11-73</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>Fell at Home</u>	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>David T. Harrison MD</u>			23B. DATE SIGNED <u>12/13/72</u>		23C. PHYSICIAN'S NAME (Type) <u>David T. Harrison MD</u>
23D. ADDRESS <u>Kirkley Funeral Home, Glen Burnie, Md.</u>			23E. DATE RECEIVED BY HEALTH DEPT. <u>DEC 14 1972</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>16 Dec. 72</u>		
24C. NAME OF CEMETERY or CREMATORY <u>Cedar Hill Cemetery</u>			24D. LOCATION (City, town, or county) (State) <u>Baltimore, AA Md.</u>		
25A. NAME OF REGISTRAR <u>Henry J. Zoltman</u>			25B. FUNERAL DIRECTOR <u>Kirkley Funeral Home, Glen Burnie, Md.</u>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 11853		72 11853	
BIRTH NO.				72 11853		72 11853	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Lester F. Jones				12-13-72			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Saint Agnes Hospital 900 South Caton Avenue				A. STATE Maryland			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				B. COUNTY			
40				C. CITY OR TOWN Baltimore			
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 44 North Kossuth Street							
5. SEX Male	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-29-1925	9. AGE (In years last birthday) 46	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Government Worker			10B. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Festgs Jones			14. MOTHER'S MAIDEN NAME Virginia Thompson				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes 4-18-44, 5-18-46			16. SOCIAL SECURITY NO. 219-12-7679		17. INFORMANT Mary Jones-44 N. Kossuth St. Balto., Md.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) I 1621 CAUSE OF DEATH Carcinoma of Lung c metastatic			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH unknown				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 11-8 1972 to 12-13 1972, that (I) (we) last saw the deceased alive on 12-9 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE David J. Mice						23B. DATE SIGNED 12-13-72	
23C. PHYSICIAN'S NAME (Type) David J. Mice			23D. ADDRESS 9115 Reisterstown Rd Owings Mills, Md.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-18-72		24C. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) (State) Arbutus (Balto. Co.) Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 14 1972			25B. NAME OF REGISTRAR Siding		25C. FUNERAL DIRECTOR Marshall W. Jones, Jr.		
			ADDRESS 4101 Edmondson Ave.				





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="float: right;">72 11854</span>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <span style="float: right;">72 11854</span> <del>STATE OF MARYLAND, DEATH</del>	
1. NAME OF DECEASED (Type or Print) <b>LUCY LONESOME</b>			2. DATE AND HOUR OF DEATH <b>12/13/72 - 9:00 AM</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Lutheran Hospital</b>			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>1506</b>		
5. SEX <b>Female</b>			6. RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>11-12-07</b>			9. AGE (In years last birthday) <b>65</b>		10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Washington Lonesome</b>		
14. MOTHER'S MAIDEN NAME <b>Katherine Washington</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		
16. SOCIAL SECURITY NO.			17. INFORMANT <b>Miss Inez Lonesome 925 Kevin Rd. 21229</b>		
18. <b>5-60-01</b>			CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <b>Acute Renal Failure</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Paralytic Ileus</b>  (B) <b>Voluntarily</b> DUE TO, OR AS A CONSEQUENCE OF:  (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <b>2</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) 1 (Month) 1 (Day) 1 (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?			22. I certify that (I) (this hospital) attended the deceased from <b>Nov 30, 1972</b> to <b>December 12, 1972</b> that (I) (we) last saw the deceased alive on <b>December 12, 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		
23A. SIGNATURE <b>FINE E. GONZALES</b>			23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <b>FINE E. GONZALES</b>
23D. ADDRESS <b>330 LUTHERAN HOSPITAL</b>			24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		
24B. DATE <b>12-16-72</b>			24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn Cemetery</b>		
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			25A. DATE REC'D BY HEALTH DEPT. <b>DEC 14 1972</b>		
25B. NAME OF REGISTRAR <b>Disney Johnson</b>			25C. FUNERAL DIRECTOR <b>Marshall W. Jones, Jr.</b>		
25D. ADDRESS <b>4101 Edmondson Ave. 21229</b>			VS 150-REV. 1/1/68		

6/10/71 - Adm.

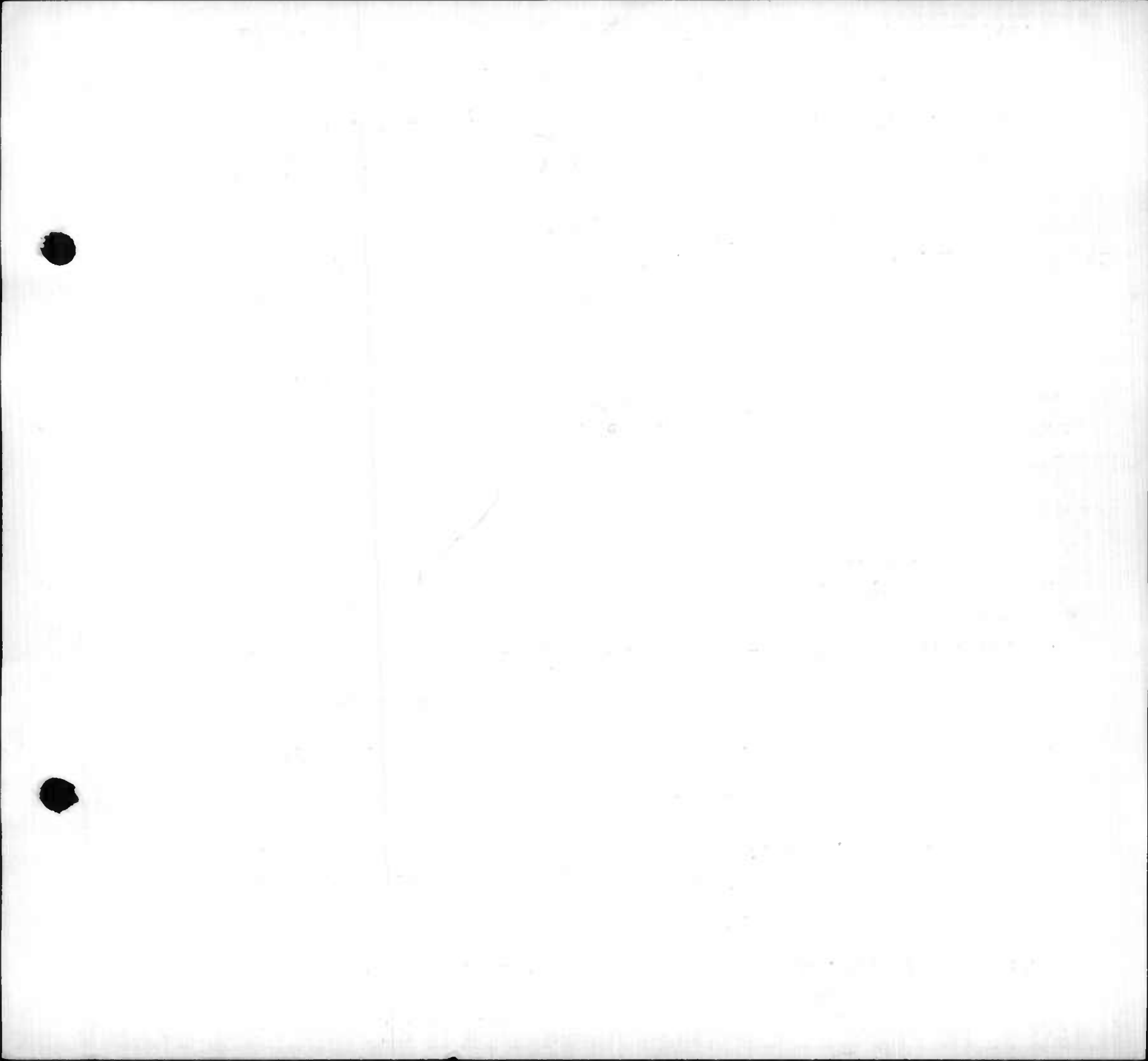
2820 W. North Ave.

St

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

RGB

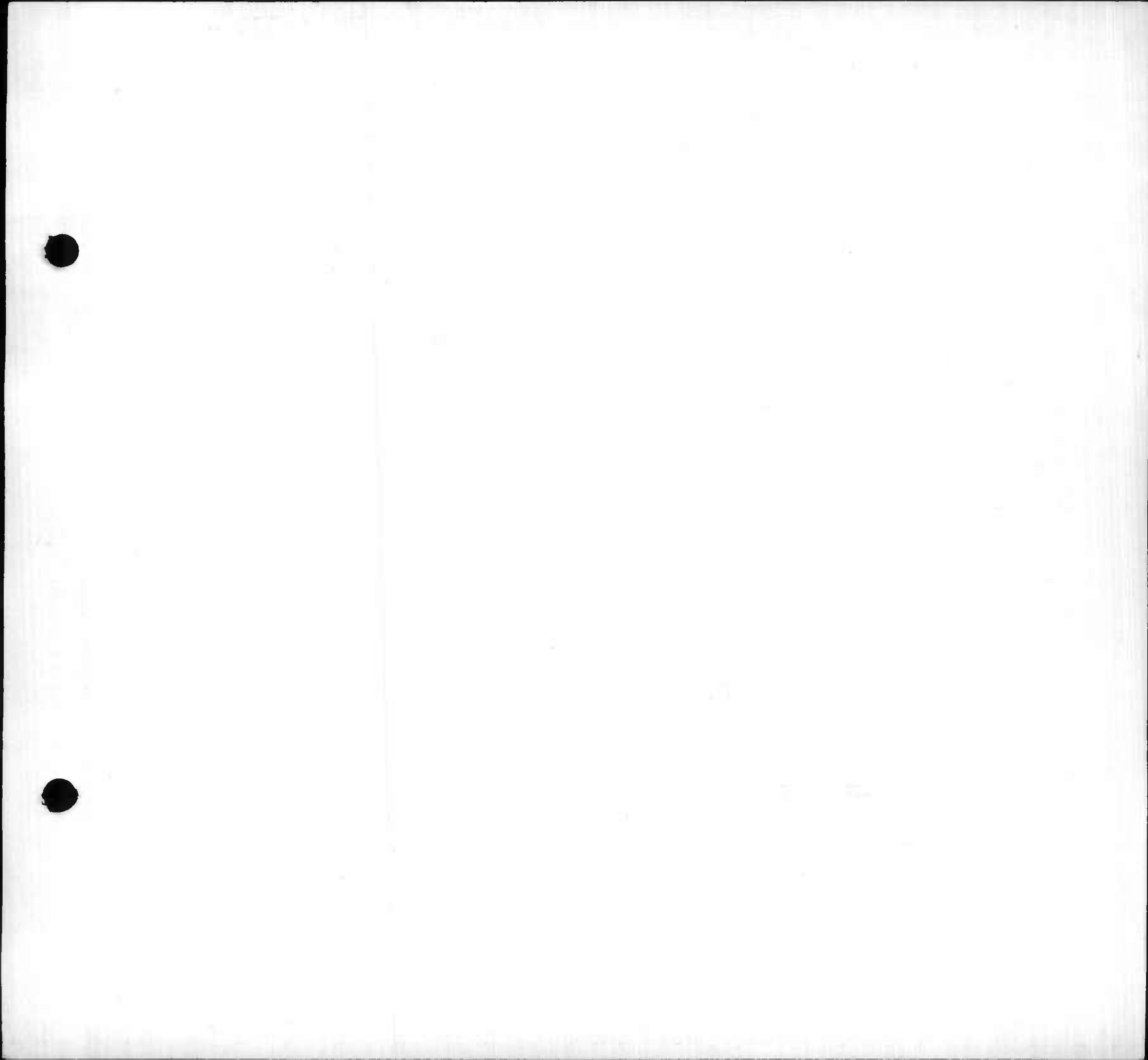
BIRTH NO.		72 11855		BALTIMORE CITY HEALTH DEPARTMENT		72 11855	
CERTIFICATE OF DEATH				REG. NO. STATE OF MARYLAND-DEATH			
1. NAME OF DECEASED (Type or Print) Warrington Roland Matthews (Smith)				2. DATE AND HOUR OF DEATH Dec. 13, 1972 5:35 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) US Public Health Service Hospital 27 3100 Wyman Parkway				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 704			
5. SEX M		6. RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/7/15	
9. AGE (In years last birthday) 57		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Metal Worker		10B. KIND OF BUSINESS OR INDUSTRY Balto. Smelting		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME George Smith			
14. MOTHER'S MAIDEN NAME Katie Smith				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 418-03-9514				17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE Bilateral pulmonary edema & congestion (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden				II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Carcinoma of left kidney with massive involvement of abdomen			
19A. DATE OF OPERATION 12/12/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Diagnosis		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Nov. 20 1972 to Dec. 13 1972 that (I) (we) last saw the deceased alive on Dec. 13 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Robert E. Belliveau, MD				23B. DATE SIGNED 12/13/72		23C. PHYSICIAN'S NAME (Type) Robert E. Belliveau, MD	
23D. ADDRESS US PHS Hospital, Balto, Md. 21211				23E. FUNERAL DIRECTOR ADDRESS Wm C March 928 E. North Ave.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-18-72		24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery		24D. LOCATION (City, town, or county) (State) Balto., MD.	
25A. DATE REC'D BY HEALTH DEPT. DEC 14 1972		25B. NAME OF REGISTRAR Adrian H. Brown		25C. FUNERAL DIRECTOR ADDRESS Wm C March 928 E. North Ave.			



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>R-300</b>      <b>72 11856</b></p>		<p><b>BALTIMORE CITY HEALTH DEPARTMENT</b></p>		<p><b>72 11856</b></p>	
<p><b>CERTIFICATE OF DEATH</b></p>		<p>REG. NO. <b>72 11856</b></p>		<p><b>STATE OF MARYLAND-DMH</b></p>	
<p>BIRTH NO. <b>RUBANA</b></p>		<p>1. NAME OF DECEASED (Type or Print) <b>LUCINDA REED</b></p>		<p>2. DATE AND HOUR OF DEATH <b>12/12/72 1645AM M.</b></p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)</p>		<p>A. STATE <b>MARYLAND</b> B. COUNTY <b>BA</b></p>	
<p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>GOOD SAMARITAN HOSPITAL 5601 LOCH RAVEN BLVD.</b></p>		<p>C. CITY OR TOWN <b>BALTIMORE</b></p>		<p>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	
<p>E. STREET AND NUMBER <b>2016 E. North Ave - 21213</b></p>		<p>5. SEX <b>FEMALE</b> 6. RACE <b>BLACK</b></p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	
<p>8. DATE OF BIRTH <b>09-07-45</b></p>		<p>9. AGE (In years last birthday) <b>27</b></p>		<p>10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.</p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b></p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p>		<p>11. BIRTHPLACE (State or foreign country) <b>S. Carolina</b></p>	
<p>12. CITIZEN OF WHAT COUNTRY?</p>		<p>13. FATHER'S NAME <b>MALLIE REED</b></p>		<p>14. MOTHER'S MAIDEN NAME <b>Lillian Robinson</b></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (If yes, no or unknown) (If yes, give war or dates of service)</p>		<p>16. SOCIAL SECURITY NO. <b>219-40-3575</b></p>		<p>17. INFORMANT ADDRESS <b>Lillian Reed 2016 E. North Ave</b></p>	
<p>18. <b>734.11</b> CAUSE OF DEATH</p>		<p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>	
<p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p>		<p>(A) IMMEDIATE CAUSE <b>Shock and Pericardial Effusion</b></p>		<p>DUE TO, OR AS A CONSEQUENCE OF: <b>with possible tamponade</b></p>	
<p>ANTECEDENT CAUSES</p>		<p>(B) <b>Systemic Lupus Erythematosus</b></p>		<p>DUE TO, OR AS A CONSEQUENCE OF:</p>	
<p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>(C)</p>		<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>	
<p>19A. DATE OF OPERATION <b>12/4</b></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>150 0 knee</b></p>		<p>20A. AUTOPSY (Yes or No) <input checked="" type="checkbox"/></p>	
<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>		<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <b>NO</b></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	
<p>21F. HOW DID INJURY OCCUR?</p>		<p>22. I certify that (I) (this hospital) attended the deceased from <b>11/20</b> 19 <b>72</b> to <b>12/12</b> 19 <b>72</b></p>		<p>that (I) (we) last saw the deceased alive on <b>12/</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>	
<p>23A. SIGNATURE <b>Gary M. Kammer MD</b></p>		<p>23B. DATE SIGNED <b>12/12/72</b></p>		<p>23C. PHYSICIAN'S NAME (Type) <b>Gary M. Kammer MD</b></p>	
<p>23D. ADDRESS <b>601 N. Broadway, Balto. Md.</b></p>		<p>24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b></p>		<p>24B. DATE <b>12-15-72</b></p>	
<p>24C. NAME OF CEMETERY or CREMATORY <b>Baltimore Cemetery</b></p>		<p>24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b></p>		<p>25A. DATE REC'D BY HEALTH DEPT. <b>DEC 14 1972</b></p>	
<p>25B. NAME OF REGISTRAR <b>Sidney Johnston</b></p>		<p>25C. FUNERAL DIRECTOR <b>Wm C March</b></p>		<p>ADDRESS <b>928 E North Ave.</b></p>	

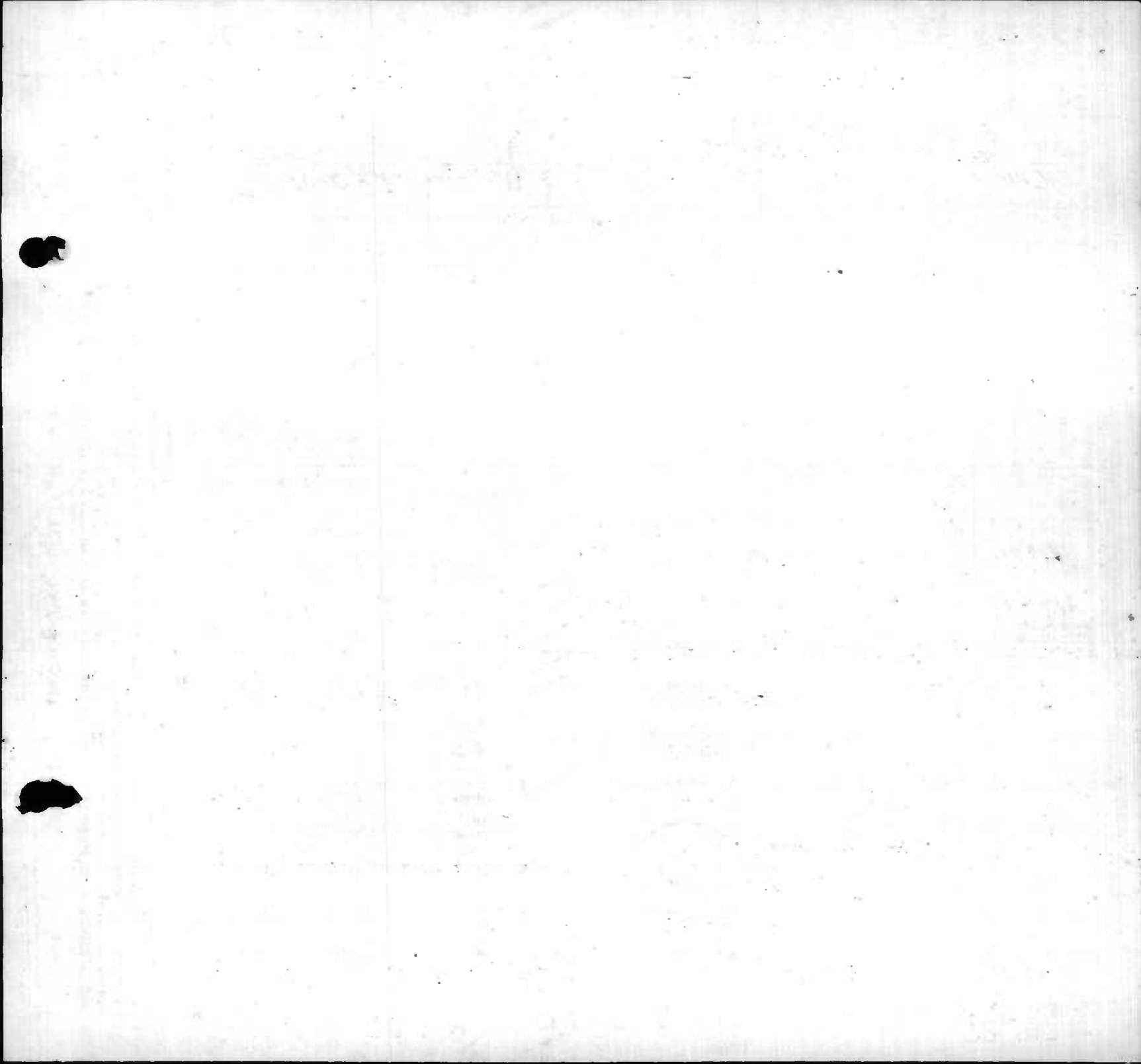


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>72 11857</b>	
N-242 72 11857		STATE OF MARYLAND-DEHM	
BIRTH NO. <b>72 11857</b>		2. DATE AND HOUR OF DEATH <b>12-11-72 1015 P</b> M.	
1. NAME OF DECEASED (Type or Print) <b>Nichols, Nathan</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2047</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Caton Manor Nursing Home</b>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Male</b>		6. RACE <b>Negro</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-9-89</b>	
9. AGE (In years last birthday) <b>83</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>Florida</b>		12. CITIZEN OF WHAT COUNTRY? <b>1964</b>	
13. FATHER'S NAME <b>William Nichols</b>		14. MOTHER'S MAIDEN NAME <b>Lydia Ann</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>705-12-4901</b>	
17. INFORMANT <b>Hattie B. Nichols</b>		ADDRESS <b>152 S. Monastery Ave.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>4-33-9 I</b> <b>Cerebral Thrombosis Complete</b> <b>Paralysis + Coma</b> <b>(A) IMMEDIATE CAUSE</b> <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <b>Cerebral Thrombosis left side</b> <b>Paralysis</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C) _____</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>11/21/72</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>19A. DATE OF OPERATION</b> <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <b>20A. AUTOPSY? (Yes or No)</b> <b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12/8</b> 1972 to <b>12/11</b> 1972, that (I) (we) last saw the deceased alive on <b>12/8</b> 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Eliot W. Johnson me</b>		23B. DATE SIGNED <b>12/11/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Eliot W. Johnson</b>		23D. ADDRESS <b>3432 E. Federal Ave.</b> <b>Baltimore Md 21239</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-15-72</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 14 1972</b>		25B. NAME OF REGISTRAR <b>Lidney Johnson</b>	
25C. FUNERAL DIRECTOR <b>Wm C March</b>		ADDRESS <b>928 E North Ave.</b>	

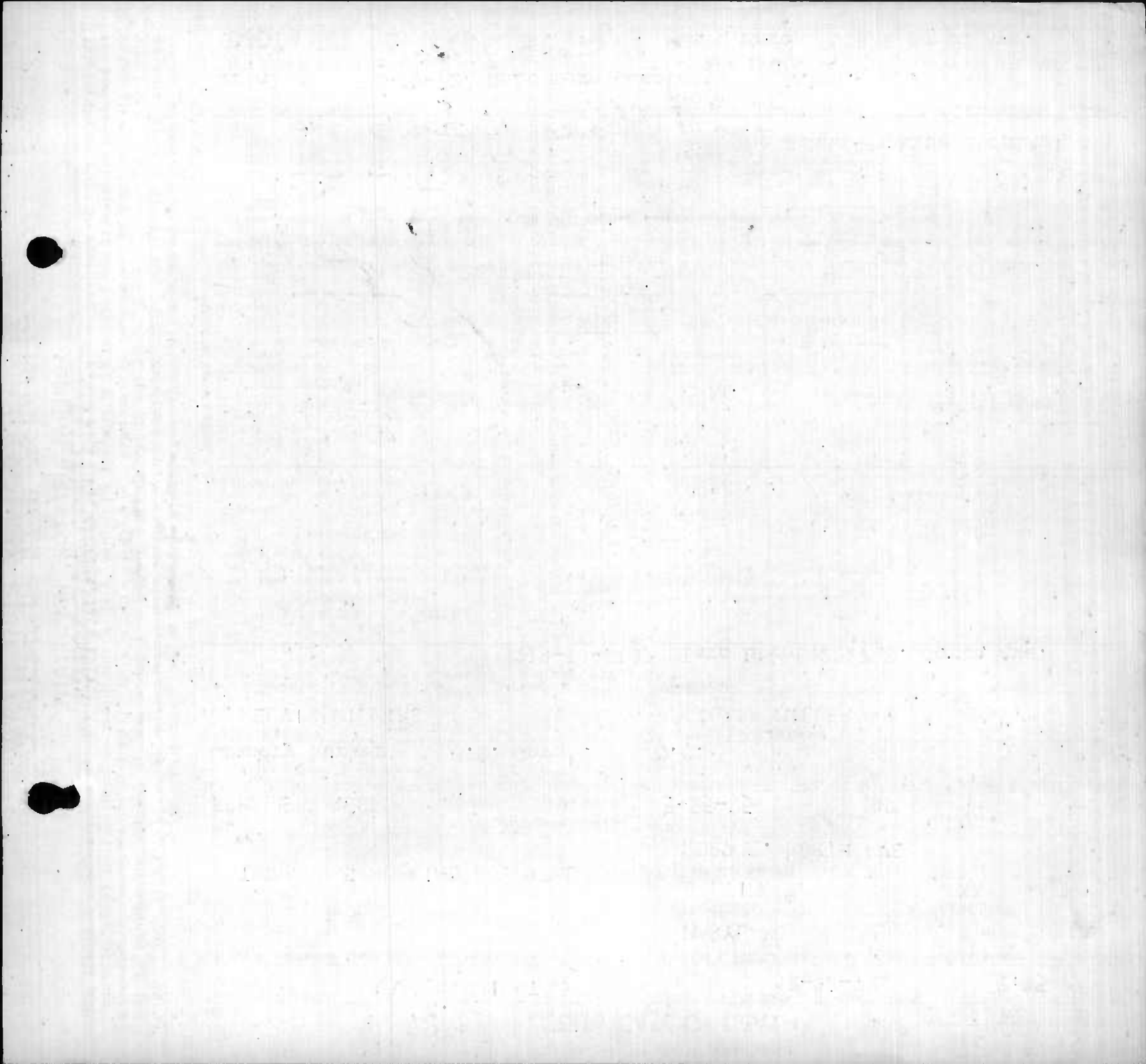




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 11858	
BIRTH NO. 72 11858				STATE OF MARYLAND-DEMF	
1. NAME OF DECEASED (Type or Print)		ROSA, WASHINGTON		2. DATE AND HOUR OF DEATH 12-12-72 7:45 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  33 THE JOHNS HOPKINS HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 802 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2227 E. NORTH AVE		
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-25-25	9. AGE (In years last birthday) 47	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundry Worker
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundry Worker			10B. KIND OF BUSINESS OR INDUSTRY U.S. Govn't		11. BIRTHPLACE (State or foreign country) N.C.
12. CITIZEN OF WHAT COUNTRY? 72 11859			13. FATHER'S NAME MELVIN WILKINS		
14. MOTHER'S MAIDEN NAME CLARA MILLER			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. 219-16-6137			17. INFORMANT Clara Brent 2227 E. North Ave.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 153.7 I Probable gram negative sepsis (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) metastatic adenocarcinoma DUE TO, OR AS A CONSEQUENCE OF: (C) of bowel (un-resectable)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 11/21 1972 to 12/12 1972, that (we) last saw the deceased alive on 12/12 1972 and that in (my) (your) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.					
23A. SIGNATURE A.S. Gritsky MD				23B. DATE SIGNED 12/12/72	
23C. PHYSICIAN'S NAME (Type) A.S. GRITSKY MD				23D. ADDRESS The Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-19-72		24C. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery	
24D. LOCATION Balto., MD.		25A. DATE REC'D BY HEALTH DEPT. DEC 14 1972			
25B. NAME OF REGISTRAR Sidney Hinton		25C. FUNERAL DIRECTOR Wm C March 928 E North Ave.			



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>CLARENCE GRESHAM JR.</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 12 10 1972 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 1931 Perlman Pl.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 10 1972 10:36am	
6. SEX male		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE negro		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 3-20-72		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (in years last birthday) 2		E. STREET AND NUMBER 1931 Perlman Pl.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Clarence Gresham Sr.		14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 802	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME Sandra Cole	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT John Watkins		ADDRESS 1819 E North Ave.	
19. <b>471X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Bronchopneumonia</b> DUE TO, OR AS A CONSEQUENCE OF:  (B) <b>Influenza</b> DUE TO, OR AS A CONSEQUENCE OF:  (C) _____  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Marvin S. Platt</b> M.D. EXAMINER'S NAME (Type) <b>Marvin S. Platt, M.D.</b>  CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>12-11-72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-14-72	
24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT <b>DEC 14 1972</b>		25B. NAME OF REGISTRAR <b>David J. March</b>	
25C. FUNERAL DIRECTOR <b>David J. March</b>		ADDRESS 928 E North Ave.	

2-15-1973 - Letter from the Office of the Chief Medical Examiner, Marvin S. Platt, M.D.,  
Assistant Medical Examiner hs

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 11860

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Jay B. Holbrook		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 11 Day 25 Year 72 Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 612 E. Lombard		3. DATE PRONOUNCED DEAD Month 11 Day 25 Year 72 Hour 12:25 a. M.	
6. SEX male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH UNK.		10. AGE (in years last birthday) 64	
11. BIRTHPLACE (State or foreign country) UNK		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME UNK		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNK	
15. MOTHER'S MAIDEN NAME UNK		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) UNK	
17. SOCIAL SECURITY NO. UNK		18. INFORMANT ADDRESS MEDICAL EXAMINERS OFFICE	
19. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  ii OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes - partial			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Peter Lipkovic, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 11/26/72			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 12-12-72	
24C. NAME OF CEMETERY or CREMATORY URM Anatomy Bldg		24D. LOCATION (City, town, or county) (State) Balt. Md	
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1972		25B. NAME OF REGISTRAR Sydney Johnston	
25C. FUNERAL DIRECTOR Raymond J. Curran		25D. ADDRESS 817 Schiller Fld Dr, Towson, MD 21204	

ACADEMIA VALERIANA



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JANE P. FORTNEY		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 3042 Guilford Ave.		3. DATE PRONOUNCED DEAD Month Day Year Hour 11 26 1972 12:50p M.	
5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 1202			
6. SEX female	7. RACE white	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH UNKNOWN	10. AGE (In years last birthday) 64	11. BIRTHPLACE (State or foreign country) UNKNOWN	12. CITIZEN OF WHAT COUNTRY? U.S.
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN		15. MOTHER'S MAIDEN NAME UNKNOWN	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN		17. SOCIAL SECURITY NO. UNKNOWN	
18. INFORMANT MEDICAL EXAMINERS OFFICE BALT. MD.		ADDRESS	
19. 412.41 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II Diabetes		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. PART I I certify that I held an inquiry <input type="checkbox"/> inspection <input type="checkbox"/> autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: [Signature] M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner 11-27-72 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 11-2-72	
24C. NAME OF CEMETERY or CREMATORY UORM Anatomy Board		24D. LOCATION (City, town, or county) (State) BALT. MD	
25A. DATE REC'D BY HEALTH DEPT DEC 15 1972		25B. NAME OF REGISTRAR Sidney Kornblum	
25C. FUNERAL DIRECTOR Raymond J. Curran		ADDRESS 817 S CARLETT DR, TOWSON, MD 21204	

ACADEMIC PROJECT

72 11862

72 11862

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

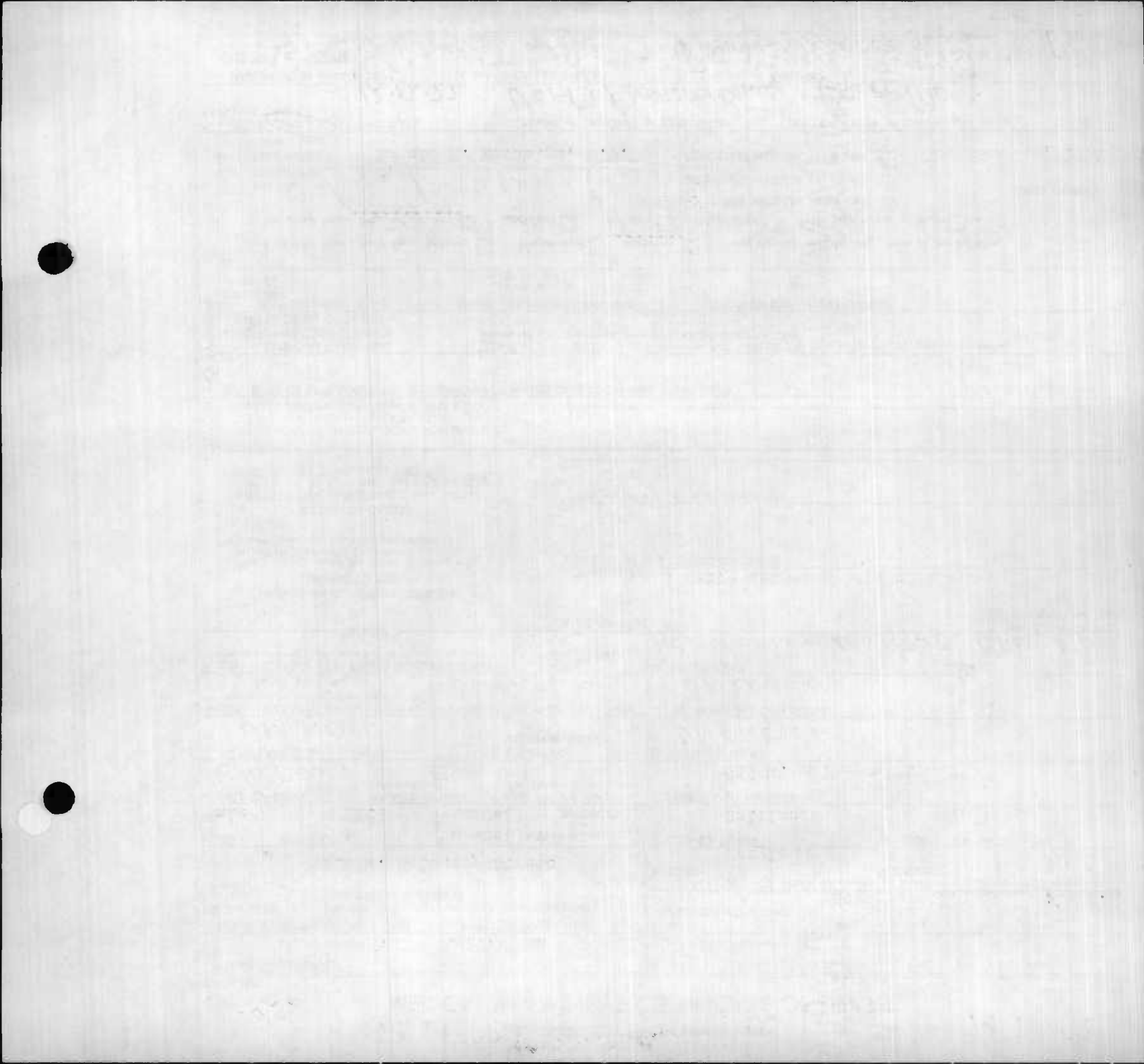
1. NAME OF DECEASED (Type or Print) <b>LEO SCHLOSSER</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 516 W. Mulberry Street</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>November 17, 1972 4:20 P.M.</b>	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>UNKNOWN</b>		10. AGE (in years last birthday) <b>65</b>	
11. BIRTHPLACE (State or foreign country) <b>UNKNOWN</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>UNKNOWN</b>		14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1701</b>	
15. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNK.</b>	
17. SOCIAL SECURITY NO. <b>UNK.</b>		18. INFORMANT ADDRESS <b>MEDICAL EXAMINERS OFFICE BALT MD</b>	

19. <b>571.81</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE <b>Fatty metamorphosis of liver</b> DUE TO, OR AS A CONSEQUENCE OF:  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			

20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>Yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	

23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>November 18, 1972</b>	

24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>12.12.72</b>		24C. NAME OF CEMETERY or CREMATORY <b>UOFM ANATOMY BOARD</b>		24D. LOCATION (City, town, or county) (State) <b>BALT. MD</b>	
25A. DATE REC'D BY HEALTH DEPT <b>DEC 15 1972</b>		25B. NAME OF REGISTRAR <b>Audrey H. [unclear]</b>		25C. FUNERAL DIRECTOR <b>RAYMOND J. CURRAN</b>		25D. ADDRESS <b>817 SCARLETT DR. TOWSON, MD 21204</b>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>WILLIAM UNDERWOOD</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>2840 Greenmount Avenue</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>November 12, 1972</b> Hour <b>10:20 A.</b>	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>904</b>	
9. DATE OF BIRTH <b>UNK.</b>		10. AGE (In years last birthday) <b>50?</b>	
11. BIRTHPLACE (State or foreign country) <b>UNK.</b>		12. CITIZEN OF WHAT COUNTRY? <b>UNK.</b>	
13. FATHER'S NAME <b>UNK.</b>		14. STREET AND NUMBER <b>2615 Greenmount Avenue</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>UNK.</b>		15. MOTHER'S MAIDEN NAME <b>UNK.</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNK.</b>		17. SOCIAL SECURITY NO. <b>UNK.</b>	
18. INFORMANT <b>MEDICAL EXAMINERS OFFICE</b>		ADDRESS <b>BALTI. MD</b>	
19. <b>571.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Fatty metamorphosis of liver</b>		CAUSE OF DEATH <b>Fatty metamorphosis of liver</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Alcoholism</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Alcoholism</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Acute laryngeal edema</b>		(B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>11/13/72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>12.12.72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>UOE. M. ANATOMY BLDG.</b>		24D. LOCATION (City, town, or county) (State) <b>BALTI. MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 15 1972</b>		25B. NAME OF REGISTRAR <b>James J. Curran</b>	
25C. FUNERAL DIRECTOR <b>James J. Curran</b>		ADDRESS <b>8175 CARLETON TOWSON, MD 21204</b>	

ACADEMIC

LIBRARY

UNIVERSITY OF

1984

1984



C-630

72 11864

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

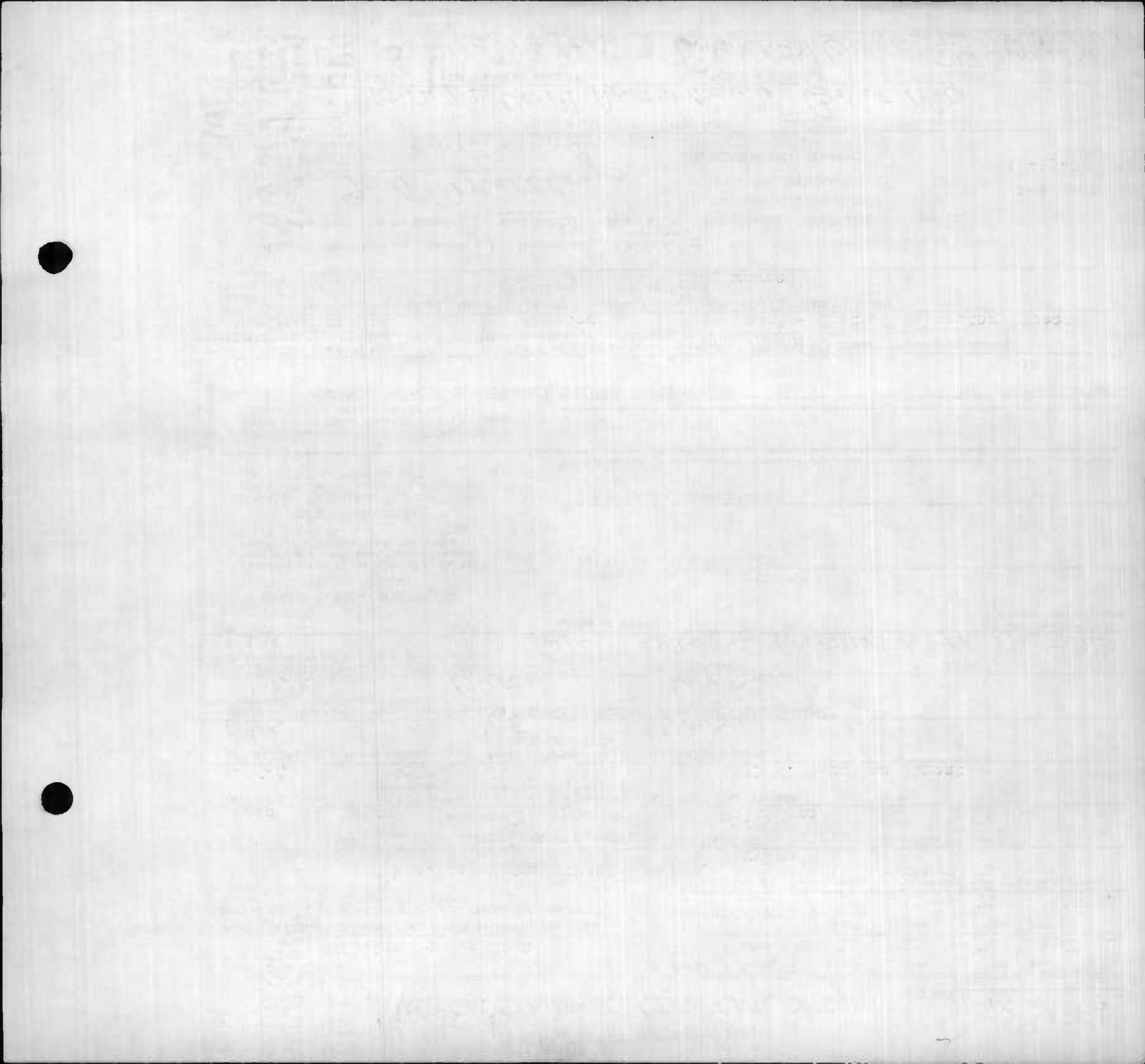
REG. NO.

72 11864

BIRTH NO.

1. NAME OF DECEASED (Type or Print) William Dennis Crut		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 10 Day 12 Year 72 Hour 1:45 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 900 blk. Lancaster Street		3. DATE PRONOUNCED DEAD Month 10 Day 12 Year 72 Hour 1:45 P.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 8-25-40		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (in years last birthday) 32		E. STREET AND NUMBER 1023 N. Caroline Street	
11. BIRTHPLACE (State or foreign country) UNK		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME UNK		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNK	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNK		15. MOTHER'S MAIDEN NAME UNK	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) UNK		17. SOCIAL SECURITY NO. UNK	
18. INFORMANT ADDRESS MEDICAL EXAMINER'S OFFICE BALT. MD.		19. CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Drowning DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C)	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Water	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Found - foot of Lancaster Street		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) Unknown	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Drowned	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE William P. Mulloy, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) William P. Mulloy, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
24A. BURIAL CREMATION REMOVAL (Specify)		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24B. DATE 10-12-72		24C. NAME OF CEMETERY or CREMATORY UOM ANATOMY BOARD	
24D. LOCATION (City, town, or county) (State) BALT. MD		25A. DATE REC'D BY HEALTH DEPT. DEC 15 1972	
25B. NAME OF REGISTRAR Sidney W. [unclear]		25C. FUNERAL DIRECTOR ADDRESS	
25D. NAME OF REGISTRAR		25E. FUNERAL DIRECTOR ADDRESS 817 S. [unclear] BALTIMORE, MD 21204	





This certificate must be proved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. No. 72 11865	
B-450 72 11865				STATE OF MARYLAND-DEATH	
1. NAME OF DECEASED (Type or Print) BLUM, WANDA IDA			2. DATE AND HOUR OF DEATH DECEMBER 10, 1972 6:20 A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST. AGNES HOSPITAL WILKENS & CATON AVENUES BALTIMORE, MARYLAND 21229			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 400 WEST SHIRE ROAD 21228		
5. SEX FEMALE	6. RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 02 03 85	9. AGE (In years last birthday) 87	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) GERMANY	
13. FATHER'S NAME AUGUST WIEHR			14. MOTHER'S MAIDEN NAME EVALINA BUSCHE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218188142		17. INFORMATION ADDRESS CATON AVENUES-BALTIMORE, MD. 21229 ST AGNES HOSPITAL RECORDS-WILKENS &	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			CAUSE OF DEATH Acute myocardial infarction (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: A.S.C. V.D. (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from DECEMBER 9, 1972 to DECEMBER 10, 1972, that (X) (we) lost saw the deceased alive on DECEMBER 10, 1972 and that (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (X) (X) view the body after death.					
23A. SIGNATURE E. Henzan			23B. DATE SIGNED 12/10/72		23C. PHYSICIAN'S NAME (Type) E. HENZAN
23D. ADDRESS BALTIMORE, MARYLAND 21229 ST AGNES HOSPITAL, WILKENS & CATON AVES.		23E. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/13/1972		24C. NAME OF CEMETERY or CREMATORY Moreland Memorial	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. DEC 15 1972			
25B. NAME OF REGISTRAR A. J. Schwab		25C. FUNERAL DIRECTOR ADDRESS G. J. Schwab 5151 Balto. Nat'l. Pike			

RECEIVED  
JANUARY 10 1950

RECEIVED

DECEMBER 9

DECEMBER 10

10

HO

RECEIVED

RECEIVED

RECEIVED

RECEIVED  
JANUARY 10 1950

RECEIVED

RECEIVED

RECEIVED  
JANUARY 10 1950

RECEIVED

RECEIVED

RECEIVED

FUNERAL DIRECTOR: IMPORTANT

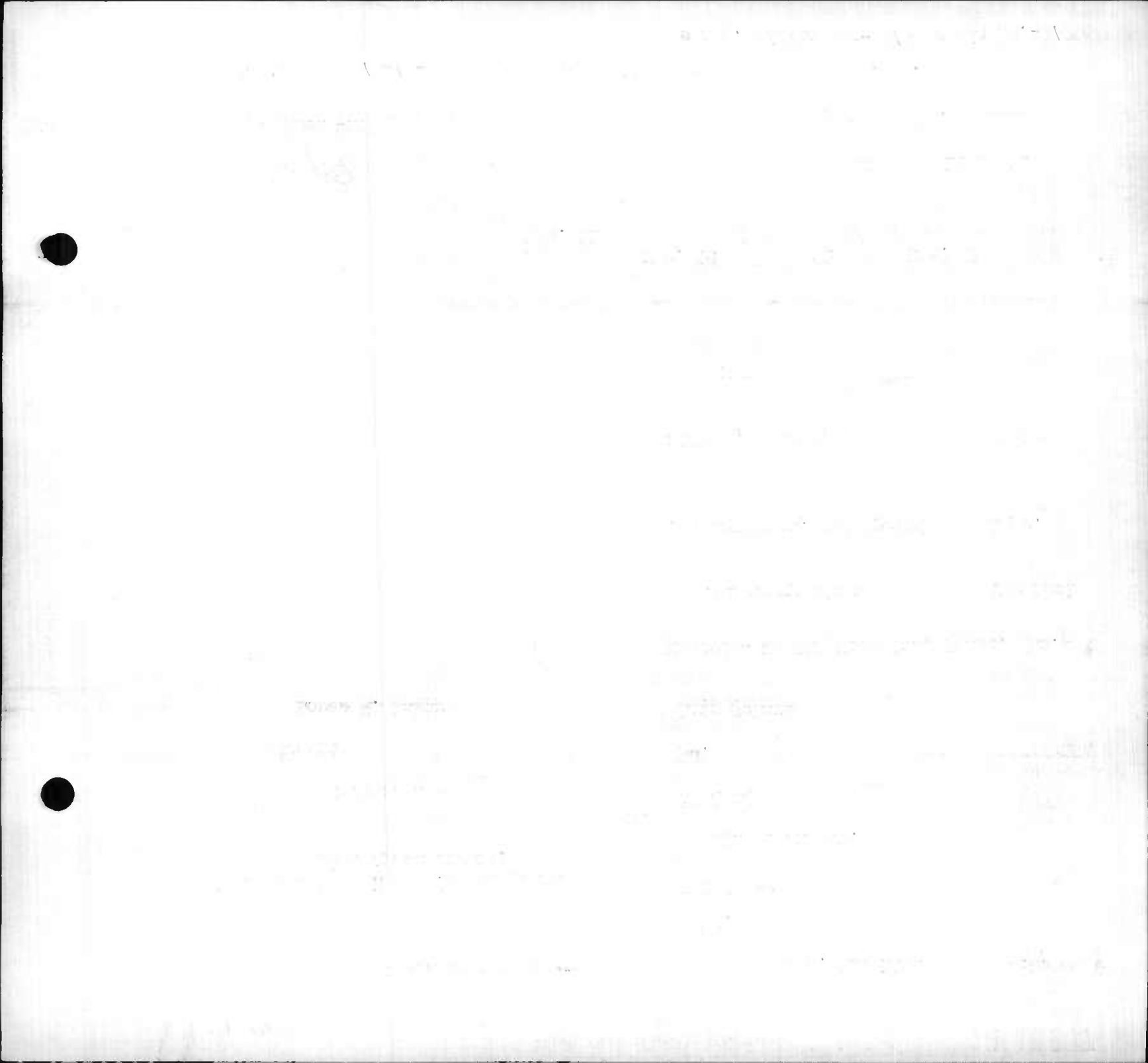
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p><b>CERTIFICATE OF DEATH</b></p>		<p>REG. NO. <b>72 11866</b></p> <p>STATE OF MARYLAND-DEPT.</p>	
<p><b>BIRTH NO.</b> <b>K-528</b></p>		<p><b>DATE AND HOUR OF DEATH</b> <b>12-10-72 1.25 AM.</b></p>	
<p><b>1. NAME OF DECEASED</b> (Type or Print) <b>LILLIAN E. KING</b></p>		<p><b>2. DATE AND HOUR OF DEATH</b> <b>12-10-72 1.25 AM.</b></p>	
<p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b></p>		<p><b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>BALTO</b></p>	
<p><b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location) <b>Luthocean Hospital of Maryland</b></p>		<p><b>C. CITY OR TOWN</b> <b>Baltimore</b> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	
<p><b>5. SEX</b> <b>F</b> <b>6. RACE</b> <b>W</b> <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/></p>		<p><b>8. DATE OF BIRTH</b> <b>12-22-16</b> <b>9. AGE</b> (In years last birthday) <b>55</b></p>	
<p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Home Maker</b></p>		<p><b>11. BIRTHPLACE</b> (State or foreign country) <b>Balto. Md.</b></p>	
<p><b>13. FATHER'S NAME</b> <b>John A. Sealover</b></p>		<p><b>14. MOTHER'S MAIDEN NAME</b> <b>Catharine B. Lemke</b></p>	
<p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b></p>		<p><b>16. SOCIAL SECURITY NO.</b> <b>-</b></p>	
<p><b>17. INFORMANT</b> <b>Mr. Cyrus King - 2 Elinor Ave. - 21206</b></p>		<p><b>ADDRESS</b></p>	
<p><b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Ch. Renal failure</b></p>		<p><b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <b>many years</b></p>	
<p><b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (At stating the UNDERLYING CONDITION last.) <b>Hypertension</b></p>		<p><b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</b> <b>Ch. Renal failure</b></p>	
<p><b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>Hypertension</b></p>		<p><b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b></p>	
<p><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b> <b>Ch. Bronchitis + Congestive Heart failure.</b></p>		<p><b>II</b></p>	
<p><b>19A. DATE OF OPERATION</b> <b>-</b> <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <b>-</b></p>		<p><b>20A. AUTOPSY?</b> (Yes or No) <b>no</b> <b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b> <b>-</b></p>	
<p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/></p>		<p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>-</b></p>	
<p><b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour) <b>-</b></p>		<p><b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	
<p><b>21F. HOW DID INJURY OCCUR?</b> <b>-</b></p>		<p><b>22. I certify that</b> (this hospital) attended the deceased from <b>11-24-1972</b> to <b>12-10-1972</b> that (I) (we) last saw the deceased alive on <b>12-10-1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>	
<p><b>23A. SIGNATURE</b> <b>M. A. ANWAR</b> <b>DEGREE</b> <b>MD.</b></p>		<p><b>23B. DATE SIGNED</b> <b>12-10-72</b></p>	
<p><b>23C. PHYSICIAN'S NAME</b> (Type) <b>M. A. ANWAR</b> <b>DEGREE</b> <b>MD.</b></p>		<p><b>23D. ADDRESS</b> <b>Luthocean Hospital of Maryland</b></p>	
<p><b>24A. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b></p>		<p><b>24B. DATE</b> <b>12-13-72</b></p>	
<p><b>24C. NAME OF CEMETERY OR CREMATORY</b> <b>Parkwood Cemetery</b></p>		<p><b>24D. LOCATION</b> (City, town, or county) (State) <b>Baltimore, Maryland</b></p>	
<p><b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>DEC 15 1972</b></p>		<p><b>25B. NAME OF REGISTRAR</b> <b>John C. Miller</b></p>	
<p><b>25C. FUNERAL DIRECTOR</b> <b>John C. Miller</b></p>		<p><b>ADDRESS</b> <b>Inc-6415 Belair Rd. - 21206</b></p>	

• •

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

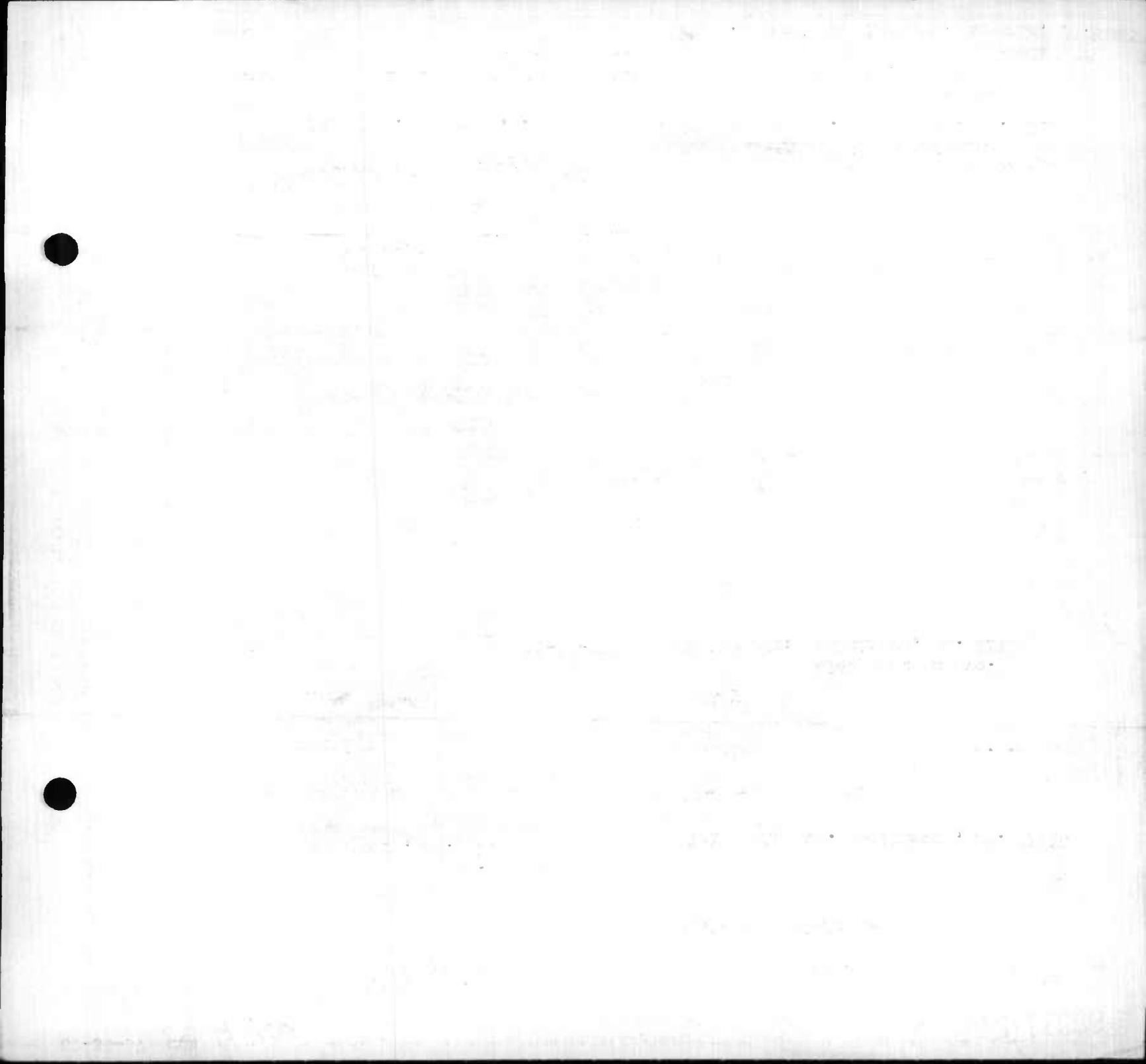
B-260		72 11867		BALTIMORE CITY HEALTH DEPARTMENT		72 11867	
CERTIFICATE OF DEATH				STATE OF MARYLAND			
1. NAME OF DECEASED (Type or Print) William Howard Baker				2. DATE AND HOUR OF DEATH Dec. 11, 1972 4:05 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) US Public Health Service Hospital 3100 Wyman Parkway				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY BALTO 5300			
5. SEX M 6. RACE Caucasian 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 10/4/54		9. AGE in years (last birthday) 18	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME Loren H. Baker				14. MOTHER'S MAIDEN NAME Lois Schaub			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. ?		17. INFORMANT Records- US PHS Hospital, Balto, Md.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary edema ANTecedent CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Lymphosarcoma, widespread				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Terminal 1 yr.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Colitis, fungus ?				Weeks			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Nov. 20 1972 to Dec. 11 1972 that (I) (we) last saw the deceased alive on Dec. 11 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE De Moraes Ruehsen, MD				23B. DATE SIGNED 12/12/72		23C. PHYSICIAN'S NAME (Type) De Moraes Ruehsen, MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 12-13-72		24C. NAME OF CEMETERY or CREMATORY Gardens of Faith Cemetery	
24D. LOCATION Balto. Md.				25A. DATE REC'D BY HEALTH DEPT. DEC 15 1972		25B. NAME OF REGISTRAR Sidney Johnston	
25C. FUNERAL DIRECTOR John C. Miller Inc-6415 Belair Rd.-21206				25D. ADDRESS John C. Miller Inc-6415 Belair Rd.-21206			





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

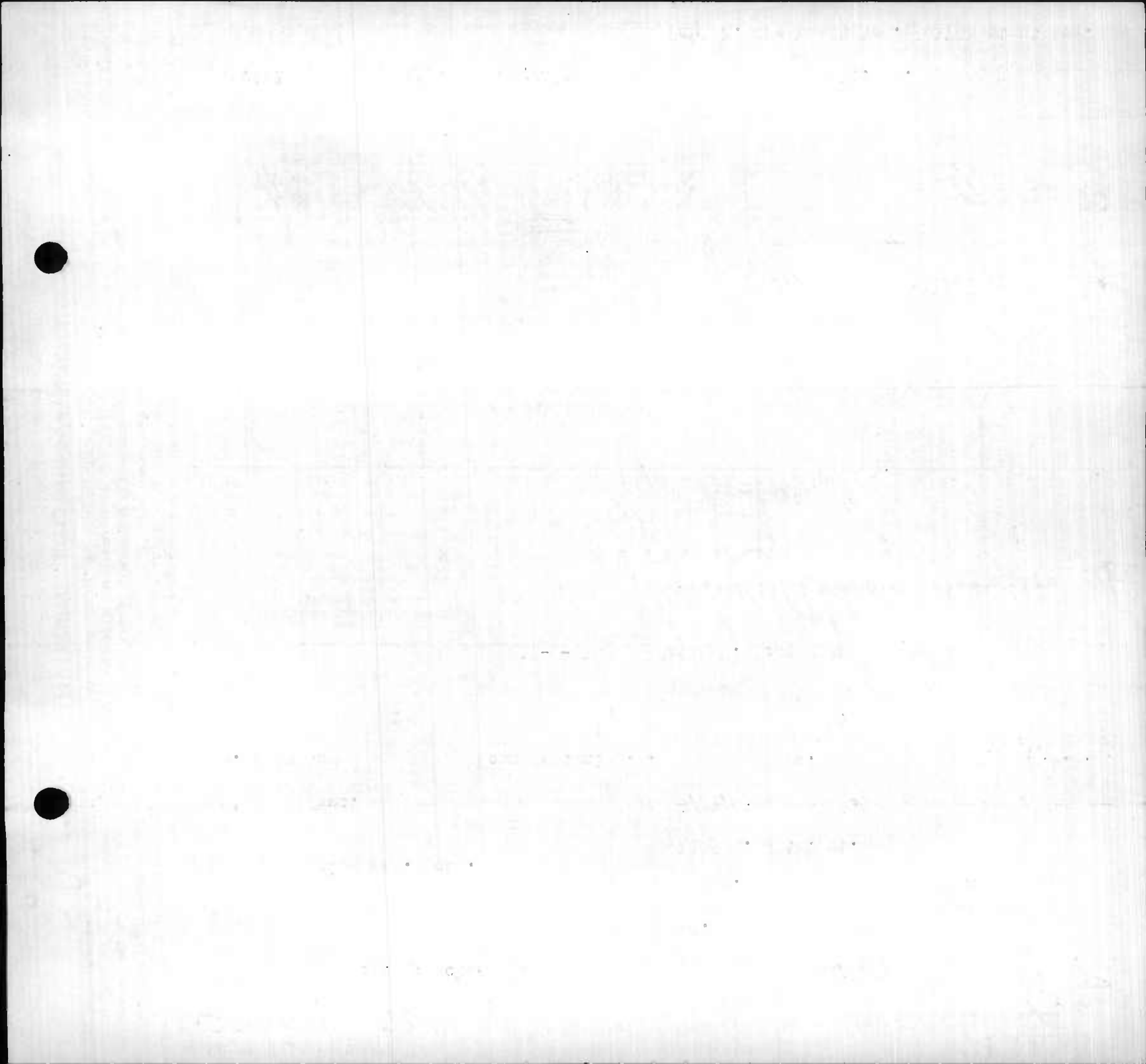
BIRTH NO.		72 11868		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO.		72 11868	
1. NAME OF DECEASED (Type or Print)				Margaret L. Hall				2. DATE AND HOUR OF DEATH			
				Margaret Hall				12/9/72 6:40 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD								4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)								A. STATE & COUNTY			
Baltimore City Hospitals								Maryland Baltimore			
4940 Eastern Ave.								C. CITY OR TOWN			
Baltimore, Md. 21224								Edgemere			
								D. INSIDE CITY LIMITS?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER								7316 Geise Ave. Baltimore, Md. 21219			
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. If Under 1 Yr. Months Days	
Female		Caucasian		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11-20-20		52			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife								Virginia		U.S.A.	
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
Ernest Duncan						Daisy					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No				213-36-0165		4940 Eastern Ave. BCH Records: Baltimore, Md. 21224					
18. CAUSE OF DEATH											
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH											
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)											
ANTECEDENT CAUSES											
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.											
(A) IMMEDIATE CAUSE M.I. DUE TO, OR AS A CONSEQUENCE OF:											
(B) RCUA DUE TO, OR AS A CONSEQUENCE OF:											
(C) Hypertension											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
20 min.											
1969											
years											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).											
19A. DATE OF OPERATION											
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED											
20A. AUTOPSY? (Yes or No)											
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)											
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)											
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)											
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)											
21E. INJURY OCCURRED											
21F. HOW DID INJURY OCCUR?											
22. I certify that (I) (this hospital) attended the deceased from 12/9/72 to 12/9/72 that (H) (we) saw the deceased alive on 12/9/72 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE											
23B. DATE SIGNED											
23C. PHYSICIAN'S NAME (Type)											
23D. ADDRESS											
Michael W. Pozen M.D. 4940 Eastern Ave. Baltimore, Md. 21224											
24A. BURIAL CREMATION, REMOVAL (Specify)											
24B. DATE											
24C. NAME OF CEMETERY or CREMATORY											
24D. LOCATION (City, town, or county) (State)											
Burial 12-13-72 Bel Air Memorial Gardens Bel Air, Maryland											
25A. DATE REC'D BY HEALTH DEPT.											
25B. NAME OF REGISTRAR											
25C. FUNERAL DIRECTOR ADDRESS											
DEC 15 1972 John J. Duda 7922 Wise Ave. Dundalk, Md. 21222											



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

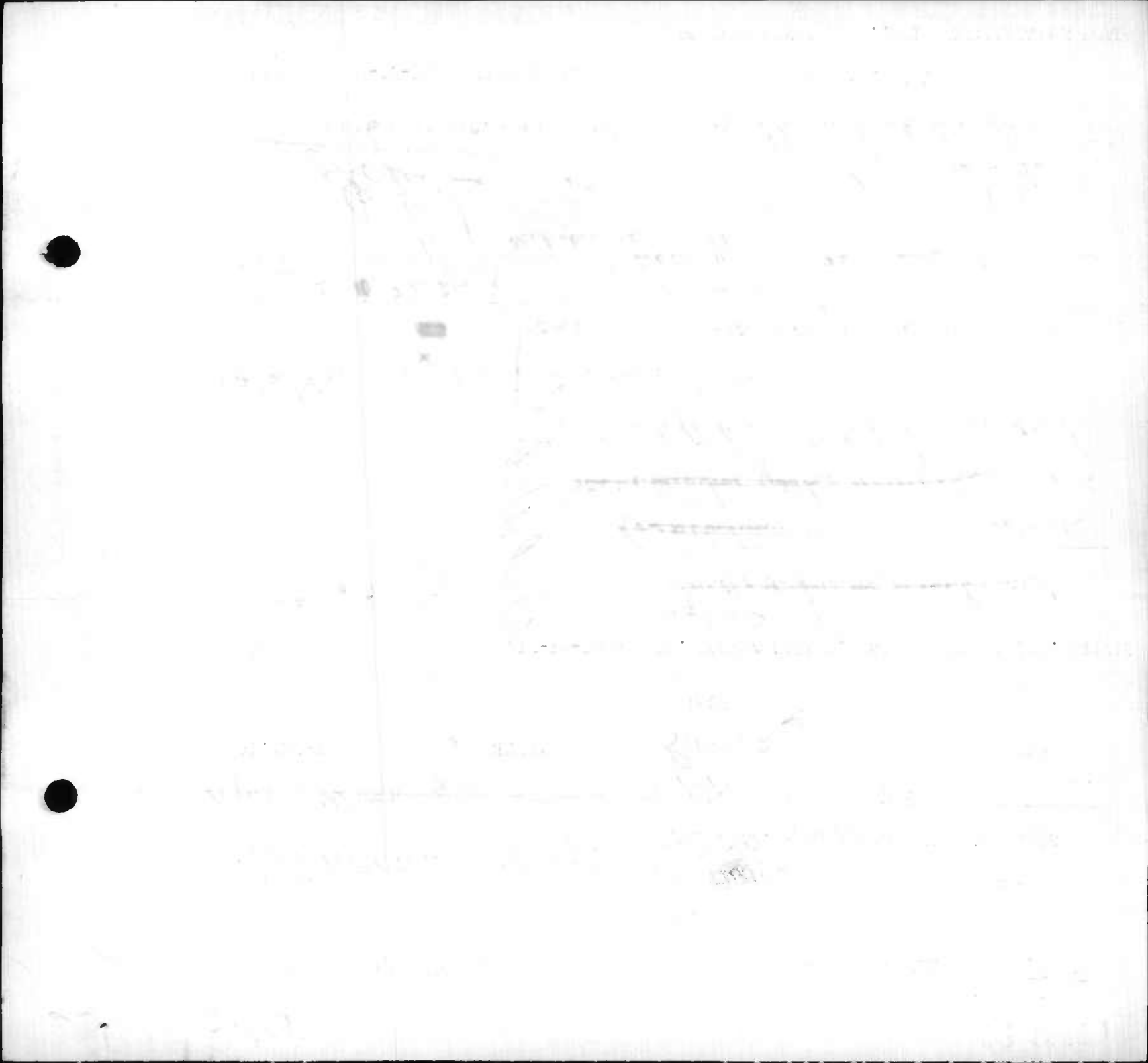
BALTIMORE CITY HEALTH DEPARTMENT											
CERTIFICATE OF DEATH											
STATE OF MARYLAND - DEPT. REG. NO. 72 11869											
BIRTH NO. <b>E-256</b>		72 11869		1. NAME OF DECEASED (Type or Print) <b>John N. Eckenrode</b>		2. DATE AND HOUR OF DEATH <b>12/11/72</b> <b>6:00</b> P.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>44 Union Mem. Hosp.</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>1307</b>				C. CITY OR TOWN <b>Balto.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX <b>Male</b> 6. RACE <b>Cauc.</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>5/21/03</b> 9. AGE (In years last birthday) <b>69</b>				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fr. Conductor</b> 11. BIRTHPLACE (State or foreign country) <b>Pa.</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>?</b>				14. MOTHER'S MAIDEN NAME <b>?</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			
16. SOCIAL SECURITY NO. <b>717-078185</b>				17. INFORMANT <b>Leila V. Eckenrode (same)</b>				ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <b>4/2/21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>Ruptured Abdominal Aneurysm - 4 Lbs</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ASCVD</b> <b>Hypertension</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Hypertension</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>1970</b> to <b>Dec 11 1972</b> , that (I) (we) last saw the deceased alive on <b>Oct 19 72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <b>[Signature]</b>								23B. DATE SIGNED <b>11-13-72</b>			
23C. PHYSICIAN'S NAME (Type) <b>[Signature]</b>								23D. ADDRESS <b>[Signature]</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>12/14/72</b>				24C. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b>			
24D. LOCATION (City, town, or county) <b>Balto Md.</b>				24E. LOCATION (State) <b>Balto Md.</b>				24F. LOCATION (Address) <b>Balto Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 15 1972</b>				25B. NAME OF REGISTRAR <b>[Signature]</b>				25C. FUNERAL DIRECTOR <b>Paul E. Chenoweth 3rd. 3617 Chestnut Ave.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-655		72 11870		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.		72 11870	
BIRTH NO.					1. NAME OF DECEASED (Type or Print) <i>Phillip B. Sherman</i>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					2. DATE AND HOUR OF DEATH <i>12-12-72 7 P</i>				
FULL NAME OF HOSPITAL OR INSTITUTION <i>Lutheran Hosp.</i>					4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <i>Md</i> B. COUNTY <i>2841</i>				
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					C. CITY OR TOWN <i>BALTO. MD</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
5. SEX <i>MALE</i>					6. RACE <i>WHITE</i>				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <i>12/5/1879</i>				
9. AGE (In years last birthday) <i>93</i>					10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>MERCHANT</i>				
11. BIRTHPLACE (State or foreign country) <i>Russia</i>					12. CITIZEN OF WHAT COUNTRY? <i>USA</i>				
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME <i>ROSA</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>					16. SOCIAL SECURITY NO. <i>212-10-7099</i>				
17. INFORMANT					ADDRESS <i>MRS. ROSINA KAPLON, 4300 RIDGEWOOD AVE. #21215</i>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>ASCVD</i> <i>Cerebral artery aneurysm</i> <i>30'</i> <i>acute</i> <i>rupture</i> <i>of the</i> <i>left</i> <i>ventricle</i> <i>of the</i> <i>heart</i> <i>due to</i> <i>arteriosclerosis</i> <i>of the</i> <i>coronary</i> <i>arteries</i> <i>and</i> <i>hypertension</i> <i>of the</i> <i>heart</i> <i>and</i> <i>kidneys</i> <i>and</i> <i>liver</i> <i>and</i> <i>spleen</i> <i>and</i> <i>pancreas</i> <i>and</i> <i>intestines</i> <i>and</i> <i>stomach</i> <i>and</i> <i>colon</i> <i>and</i> <i>rectum</i> <i>and</i> <i>anus</i> <i>and</i> <i>ureters</i> <i>and</i> <i>bladder</i> <i>and</i> <i>prostate</i> <i>and</i> <i>testes</i> <i>and</i> <i>epididymis</i> <i>and</i> <i>penis</i> <i>and</i> <i>scrotum</i> <i>and</i> <i>perineum</i> <i>and</i> <i>anal</i> <i>and</i> <i>rectal</i> <i>and</i> <i>sigmoid</i> <i>and</i> <i>transverse</i> <i>and</i> <i>descending</i> <i>and</i> <i>ascending</i> <i>and</i> <i>ileocecal</i> <i>and</i> <i>terminal</i> <i>and</i> <i>sigmoid</i> <i>and</i> <i>rectal</i> <i>and</i> <i>anal</i> <i>and</i> <i>perineum</i> <i>and</i> <i>scrotum</i> <i>and</i> <i>penis</i> <i>and</i> <i>testes</i> <i>and</i> <i>epididymis</i> <i>and</i> <i>prostate</i> <i>and</i> <i>bladder</i> <i>and</i> <i>ureters</i> <i>and</i> <i>kidneys</i> <i>and</i> <i>pancreas</i> <i>and</i> <i>spleen</i> <i>and</i> <i>liver</i> <i>and</i> <i>stomach</i> <i>and</i> <i>intestines</i> <i>and</i> <i>colon</i> <i>and</i> <i>rectum</i> <i>and</i> <i>anus</i> <i>and</i> <i>perineum</i> <i>and</i> <i>scrotum</i> <i>and</i> <i>penis</i> <i>and</i> <i>testes</i> <i>and</i> <i>epididymis</i> <i>and</i> <i>prostate</i> <i>and</i> <i>bladder</i> <i>and</i> <i>ureters</i> <i>and</i> <i>kidneys</i> <i>and</i> <i>pancreas</i> <i>and</i> <i>spleen</i> <i>and</i> <i>liver</i> <i>and</i> <i>stomach</i> <i>and</i> <i>intestines</i> <i>and</i> <i>colon</i> <i>and</i> <i>rectum</i> <i>and</i> <i>anus</i> <i>and</i> <i>perineum</i> <i>and</i> <i>scrotum</i> <i>and</i> <i>penis</i> <i>and</i> <i>testes</i> <i>and</i> <i>epididymis</i> <i>and</i> <i>prostate</i> <i>and</i> <i>bladder</i> <i>and</i> <i>ureters</i> <i>and</i> <i>kidneys</i> <i>and</i> <i>pancreas</i> <i>and</i> <i>spleen</i> <i>and</i> <i>liver</i> <i>and</i> <i>stomach</i> <i>and</i> <i>intestines</i> <i>and</i> <i>colon</i> <i>and</i> <i>rectum</i> <i>and</i> <i>anus</i> <i>and</i> <i>perineum</i> <i>and</i> <i>scrotum</i> <i>and</i> <i>penis</i> <i>and</i> <i>testes</i> <i>and</i> <i>epididymis</i> <i>and</i> <i>prostate</i> <i>and</i> <i>bladder</i> <i>and</i> <i>ureters</i> <i>and</i> <i>kidneys</i> <i>and</i> <i>pancreas</i> <i>and</i> <i>spleen</i> <i>and</i> <i>liver</i> <i>and</i> <i>stomach</i> <i>and</i> <i>intestines</i> <i>and</i> <i>colon</i> <i>and</i> <i>rectum</i> <i>and</i> <i>anus</i> <i>and</i> <i>perineum</i> <i>and</i> <i>scrotum</i> <i>and</i> <i>penis</i> <i>and</i> <i>testes</i> <i>and</i> <i>epididymis</i> <i>and</i> <i>prostate</i> <i>and</i> <i>bladder</i> <i>and</i> <i>ureters</i> <i>and</i> <i>kidneys</i> <i>and</i> <i>pancreas</i> <i>and</i> <i>spleen</i> <i>and</i> <i>liver</i> <i>and</i> <i>stomach</i> <i>and</i> <i>intestines</i> <i>and</i> <i>colon</i> <i>and</i> <i>rectum</i> <i>and</i> <i>anus</i> <i>and</i> <i>perineum</i> <i>and</i> <i>scrotum</i> <i>and</i> <i>penis</i> <i>and</i> <i>testes</i> <i>and</i> <i>epididymis</i> <i>and</i> <i>prostate</i> <i>and</i> <i>bladder</i> <i>and</i> <i>ureters</i> <i>and</i> <i>kidneys</i> <i>and</i> <i>pancreas</i> <i>and</i> <i>spleen</i> <i>and</i> <i>liver</i> <i>and</i> <i>stomach</i> <i>and</i> <i>intestines</i> <i>and</i> <i>colon</i> <i>and</i> <i>rectum</i> <i>and</i> <i>anus</i> <i>and</i> <i>perineum</i> <i>and</i> <i>scrotum</i> <i>and</i> <i>penis</i> <i>and</i> <i>testes</i> <i>and</i> <i>epididymis</i> <i>and</i> <i>prostate</i> <i>and</i> <i>bladder</i> <i>and</i> <i>ureters</i> <i>and</i> <i>kidneys</i> <i>and</i> <i>pancreas</i> <i>and</i> <i>spleen</i> <i>and</i> <i>liver</i> <i>and</i> <i>stomach</i> <i>and</i> <i>intestines</i> <i>and</i> <i>colon</i> <i>and</i> <i>rectum</i> <i>and</i> <i>anus</i> <i>and</i> <i>perineum</i> <i>and</i> <i>scrotum</i> <i>and</i> <i>penis</i> <i>and</i> <i>testes</i> <i>and</i> <i>epididymis</i> <i>and</i> <i>prostate</i> <i>and</i> <i>bladder</i> <i>and</i> <i>ureters</i> <i>and</i> <i>kidneys</i> <i>and</i> <i>pancreas</i> <i>and</i> <i>spleen</i> <i>and</i> <i>liver</i> <i>and</i> <i>stomach</i> <i>and</i> <i>intestines</i> <i>and</i> <i>colon</i> <i>and</i> <i>rectum</i> <i>and</i> <i>anus</i> <i>and</i> <i>perineum</i> <i>and</i> <i>scrotum</i> <i>and</i> <i>penis</i> <i>and</i> <i>testes</i> <i>and</i> <i>epididymis</i> <i>and</i> <i>prostate</i> <i>and</i> <i>bladder</i> <i>and</i> <i>ureters</i> <i>and</i> <i>kidneys</i> <i>and</i> <i>pancreas</i> <i>and</i> <i>spleen</i> <i>and</i> <i>liver</i> <i>and</i> <i>stomach</i> <i>and</i> <i>intestines</i> <i>and</i> <i>colon</i> <i>and</i> <i>rectum</i> <i>and</i> <i>anus</i> <i>and</i> <i>perineum</i> <i>and</i> <i>scrotum</i> <i>and</i> <i>penis</i> <i>and</i> <i>testes</i> <i>and</i> <i>epididymis</i> <i>and</i> <i>prostate</i> <i>and</i> <i>bladder</i> <i>and</i> <i>ureters</i> <i>and</i> <i>kidneys</i> <i>and</i> <i>pancreas</i> <i>and</i> <i>spleen</i> <i>and</i> <i>liver</i> <i>and</i> <i>stomach</i> <i>and</i> <i>intestines</i> <i>and</i> <i>colon</i> <i>and</i> <i>rectum</i> <i>and</i> <i>anus</i> <i>and</i> <i>perineum</i> <i>and</i> <i>scrotum</i> <i>and</i> <i>penis</i> <i>and</i> <i>testes</i> <i>and</i> <i>epididymis</i> <i>and</i> <i>prostate</i> <i>and</i> <i>bladder</i> <i>and</i> <i>ureters</i> <i>and</i> <i>kidneys</i> <i>and</i> <i>pancreas</i> <i>and</i> <i>spleen</i> <i>and</i> <i>liver</i> <i>and</i> <i>stomach</i> <i>and</i> <i>intestines</i> <i>and</i> <i>colon</i> <i>and</i> <i>rectum</i> <i>and</i> <i>anus</i> <i>and</i> <i>perineum</i> <i>and</i> <i>scrotum</i> <i>and</i> <i>penis</i> <i>and</i> <i>testes</i> <i>and</i> <i>epididymis</i> <i>and</i> <i>prostate</i> <i>and</i> <i>bladder</i> <i>and</i> <i>ureters</i> <i>and</i> <i>kidneys</i> <i>and</i> <i>pancreas</i> <i>and</i> <i>spleen</i> <i>and</i> <i>liver</i> <i>and</i> <i>stomach</i> <i>and</i> <i>intestines</i> <i>and</i> <i>colon</i> <i>and</i> <i>rectum</i> <i>and</i> <i>anus</i> <i>and</i> <i>perineum</i> <i>and</i> <i>scrotum</i> <i>and</i> <i>penis</i> <i>and</i> <i>testes</i> <i>and</i> <i>epididymis</i> <i>and</i> <i>prostate</i> <i>and</i> <i>bladder</i> <i>and</i> <i>ureters</i> <i>and</i> <i>kidneys</i> <i>and</i> <i>pancreas</i> <i>and</i> <i>spleen</i> <i>and</i> <i>liver</i> <i>and</i> <i>stomach</i> <i>and</i> <i>intestines</i> <i>and</i> <i>colon</i> <i>and</i> <i>rectum</i> <i>and</i> <i>anus</i> <i>and</i> <i>perineum</i> <i>and</i> <i>scrotum</i> <i>and</i> <i>penis</i> <i>and</i> <i>testes</i> <i>and</i> <i>epididymis</i> <i>and</i> <i>prostate</i> <i>and</i> <i>bladder</i> <i>and</i> <i>ureters</i> <i>and</i> <i>kidneys</i> <i>and</i> <i>pancreas</i> <i>and</i> <i>spleen</i> <i>and</i> <i>liver</i> <i>and</i> <i>stomach</i> <i>and</i> <i>intestines</i> <i>and</i> <i>colon</i> <i>and</i> <i>rectum</i> <i>and</i> <i>anus</i> <i>and</i> <i>perineum</i> <i>and</i> <i>scrotum</i> <i>and</i> <i>penis</i> <i>and</i> <i>testes</i> <i>and</i> <i>epididymis</i> <i>and</i> <i>prostate</i> <i>and</i> <i>bladder</i> <i>and</i> <i>ureters</i> <i>and</i> <i>kidneys</i> <i>and</i> <i>pancreas</i> <i>and</i> <i>spleen</i> <i>and</i> <i>liver</i> <i>and</i> <i>stomach</i> <i>and</i> <i>intestines</i> <i>and</i> <i>colon</i> <i>and</i> <i>rectum</i> <i>and</i> <i>anus</i> <i>and</i> <i>perineum</i> <i>and</i> <i>scrotum</i> <i>and</i> <i>penis</i> <i>and</i> <i>testes</i> <i>and</i> <i>epididymis</i> <i>and</i> <i>prostate</i> <i>and</i> <i>bladder</i> <i>and</i> <i>ureters</i> <i>and</i> <i>kidneys</i> <i>and</i> <i>pancreas</i> <i>and</i> <i>spleen</i> <i>and</i> <i>liver</i> <i>and</i> <i>stomach</i> <i>and</i> <i>intestines</i> <i>and</i> <i>colon</i> <i>and</i> <i>rectum</i> <i>and</i> <i>anus</i> <i>and</i> <i>perineum</i> <i>and</i> <i>scrotum</i> <i>and</i> <i>penis</i> <i>and</i> <i>testes</i> <i>and</i> <i>epididymis</i> <i>and</i> <i>prostate</i> <i>and</i> <i>bladder</i> <i>and</i> <i>ureters</i> <i>and</i> <i>kidneys</i> <i>and</i> <i>pancreas</i> <i>and</i> <i>spleen</i> <i>and</i> <i>liver</i> <i>and</i> <i>stomach</i> <i>and</i> <i>intestines</i> <i>and</i> <i>colon</i> <i>and</i> <i>rectum</i> <i>and</i> <i>anus</i> <i>and</i> <i>perineum</i> <i>and</i> <i>scrotum</i> <i>and</i> <i>penis</i> <i>and</i> <i>testes</i> <i>and</i> <i>epididymis</i> <i>and</i> <i>prostate</i> <i>and</i> <i>bladder</i> <i>and</i> <i>ureters</i> <i>and</i> <i>kidneys</i> <i>and</i> <i>pancreas</i> <i>and</i> <i>spleen</i> <i>and</i> <i>liver</i> <i>and</i> <i>stomach</i> <i>and</i> <i>intestines</i> <i>and</i> <i>colon</i> <i>and</i> <i>rectum</i> <i>and</i> <i>anus</i> <i>and</i> <i>perineum</i> <i>and</i> <i>scrotum</i> <i>and</i> <i>penis</i> <i>and</i> <i>testes</i> <i>and</i> <i>epididymis</i> <i>and</i> <i>prostate</i> <i>and</i> <i>bladder</i> <i>and</i> <i>ureters</i> <i>and</i> <i>kidneys</i> <i>and</i> <i>pancreas</i> <i>and</i> <i>spleen</i> <i>and</i> <i>liver</i> <i>and</i> <i>stomach</i> <i>and</i> <i>intestines</i> <i>and</i> <i>colon</i> <i>and</i> <i>rectum</i> <i>and</i> <i>anus</i> <i>and</i> <i>perineum</i> <i>and</i> <i>scrotum</i> <i>and</i> <i>penis</i> <i>and</i> <i>testes</i> <i>and</i> <i>epididymis</i> <i>and</i> <i>prostate</i> <i>and</i> <i>bladder</i> <i>and</i> <i>ureters</i> <i>and</i> <i>kidneys</i> <i>and</i> <i>pancreas</i> <i>and</i> <i>spleen</i> <i>and</i> <i>liver</i> <i>and</i> <i>stomach</i> <i>and</i> <i>intestines</i> <i>and</i> <i>colon</i> <i>and</i> <i>rectum</i> <i>and</i> <i>anus</i> <i>and</i> <i>perineum</i> <i>and</i> <i>scrotum</i> <i>and</i> <i>penis</i> <i>and</i> <i>testes</i> <i>and</i> <i>epididymis</i> <i>and</i> <i>prostate</i> <i>and</i> <i>bladder</i> <i>and</i> <i>ureters</i> <i>and</i> <i>kidneys</i> <i>and</i> <i>pancreas</i> <i>and</i> <i>spleen</i> <i>and</i> <i>liver</i> <i>and</i> <i>stomach</i> <i>and</i> <i>intestines</i> <i>and</i> <i>colon</i> <i>and</i> <i>rectum</i> <i>and</i> <i>anus</i> <i>and</i> <i>perineum</i> <i>and</i> <i>scrotum</i> <i>and</i> <i>penis</i> <i>and</i> <i>testes</i> <i>and</i> <i>epididymis</i> <i>and</i> <i>prostate</i> <i>and</i> <i>bladder</i> <i>and</i> <i>ureters</i> <i>and</i> <i>kidneys</i> <i>and</i> <i>pancreas</i> <i>and</i> <i>spleen</i> <i>and</i> <i>liver</i> <i>and</i> <i>stomach</i> <i>and</i> <i>intestines</i> <i>and</i> <i>colon</i> <i>and</i> <i>rectum</i> <i>and</i> <i>anus</i> <i>and</i> <i>perineum</i> <i>and</i> <i>scrotum</i> <i>and</i> <i>penis</i> <i>and</i> <i>testes</i> <i>and</i> <i>epididymis</i> <i>and</i> <i>prostate</i> <i>and</i> <i>bladder</i> <i>and</i> <i>ureters</i> <i>and</i> <i>kidneys</i> <i>and</i> <i>pancreas</i> <i>and</i> <i>spleen</i> <i>and</i> <i>liver</i> <i>and</i> <i>stomach</i> <i>and</i> <i>intestines</i> <i>and</i> <i>colon</i> <i>and</i> <i>rectum</i> <i>and</i> <i>anus</i> <i>and</i> <i>perineum</i> <i>and</i> <i>scrotum</i> <i>and</i> <i>penis</i> <i>and</i> <i>testes</i> <i>and</i> <i>epididymis</i> <i>and</i> <i>prostate</i> <i>and</i> <i>bladder</i> <i>and</i> <i>ureters</i> <i>and</i> <i>kidneys</i> <i>and</i> <i>pancreas</i> <i>and</i> <i>spleen</i> <i>and</i> <i>liver</i> <i>and</i> <i>stomach</i> <i>and</i> <i>intestines</i> <i>and</i> <i>colon</i> <i>and</i> <i>rectum</i> <i>and</i> <i>anus</i> <i>and</i> <i>perineum</i> <i>and</i> <i>scrotum</i> <i>and</i> <i>penis</i> <i>and</i> <i>testes</i> <i>and</i> <i>epididymis</i> <i>and</i> <i>prostate</i> <i>and</i> <i>bladder</i> <i>and</i> <i>ureters</i> <i>and</i> <i>kidneys</i> <i>and</i> <i>pancreas</i> <i>and</i> <i>spleen</i> <i>and</i> <i>liver</i> <i>and</i> <i>stomach</i> <i>and</i> <i>intestines</i> <i>and</i> <i>colon</i> <i>and</i> <i>rectum</i> <i>and</i> <i>anus</i> <i>and</i> <i>perineum</i> <i>and</i> <i>scrotum</i> <i>and</i> <i>penis</i> <i>and</i> <i>testes</i> <i>and</i> <i>epididymis</i> <i>and</i> <i>prostate</i> <i>and</i> <i>bladder</i> <i>and</i> <i>ureters</i> <i>and</i> <i>kidneys</i> <i>and</i> <i>pancreas</i> <i>and</i> <i>spleen</i> <i>and</i> <i>liver</i> <i>and</i> <i>stomach</i> <i>and</i> <i>intestines</i> <i>and</i> <i>colon</i> <i>and</i> <i>rectum</i> <i>and</i> <i>anus</i> <i>and</i> <i>perineum</i> <i>and</i> <i>scrotum</i> <i>and</i> <i>penis</i> <i>and</i> <i>testes</i> <i>and</i> <i>epididymis</i> <i>and</i> <i>prostate</i> <i>and</i> <i>bladder</i> <i>and</i> <i>ureters</i> <i>and</i> <i>kidneys</i> <i>and</i> <i>pancreas</i> <i>and</i> <i>spleen</i> <i>and</i> <i>liver</i> <i>and</i> <i>stomach</i> <i>and</i> <i>intestines</i> <i>and</i> <i>colon</i> <i>and</i> <i>rectum</i> <i>and</i> <i>anus</i> <i>and</i> <i>perineum</i> <i>and</i> <i>scrotum</i> <i>and</i> <i>penis</i> <i>and</i> <i>testes</i> <i>and</i> <i>epididymis</i> <i>and</i> <i>prostate</i> <i>and</i> <i>bladder</i> <i>and</i> <i>ureters</i> <i>and</i> <i>kidneys</i> <i>and</i> <i>pancreas</i> <i>and</i> <i>spleen</i> <i>and</i> <i>liver</i> <i>and</i> <i>stomach</i> <i>and</i> <i>intestines</i> <i>and</i> <i>colon</i> <i>and</i> <i>rectum</i> <i>and</i> <i>anus</i> <i>and</i> <i>perineum</i> <i>and</i> <i>scrotum</i> <i>and</i> <i>penis</i> <i>and</i> <i>testes</i> <i>and</i> <i>epididymis</i> <i>and</i> <i>prostate</i> <i>and</i> <i>bladder</i> <i>and</i> <i>ureters</i> <i>and</i> <i>kidneys</i> <i>and</i> <i>pancreas</i> <i>and</i> <i>spleen</i> <i>and</i> <i>liver</i> <i>and</i> <i>stomach</i> <i>and</i> <i>intestines</i> <i>and</i> <i>colon</i> <i>and</i> <i>rectum</i> <i>and</i> <i>anus</i> <i>and</i> <i>perineum</i> <i>and</i> <i>scrotum</i> <i>and</i> <i>penis</i> <i>and</i> <i>testes</i> <i>and</i> <i>epididymis</i> <i>and</i> <i>prostate</i> <i>and</i> <i>bladder</i> <i>and</i> <i>ureters</i> <i>and</i> <i>kidneys</i> <i>and</i> <i>pancreas</i> <i>and</i> <i>spleen</i> <i>and</i> <i>liver</i> <i>and</i> <i>stomach</i> <i>and</i> <i>intestines</i> <i>and</i> <i>colon</i> <i>and</i> <i>rectum</i> <i>and</i> <i>anus</i> <i>and</i> <i>perineum</i> <i>and</i> <i>scrotum</i> <i>and</i> <i>penis</i> <i>and</i> <i>testes</i> <i>and</i> <i>epididymis</i> <i>and</i> <i>prostate</i> <i>and</i> <i>bladder</i> <i>and</i> <i>ureters</i> <i>and</i> <i>kidneys</i> <i>and</i> <i>pancreas</i> <i>and</i> <i>spleen</i> <i>and</i> <i>liver</i> <i>and</i> <i>stomach</i> <i>and</i> <i>intestines</i> <i>and</i> <i>colon</i> <i>and</i> <i>rectum</i> <i>and</i> <i>anus</i> <i>and</i> <i>perineum</i> <i>and</i> <i>scrotum</i> <i>and</i> <i>penis</i> <i>and</i> <i>testes</i> <i>and</i> <i>epididymis</i> <i>and</i> <i>prostate</i> <i>and</i> <i>bladder</i> <i>and</i> <i>ureters</i> <i>and</i> <i>kidneys</i> <i>and</i> <i>pancreas</i> <i>and</i> <i>spleen</i> <i>and</i> <i>liver</i> <i>and</i> <i>stomach</i> <i>and</i> <i>intestines</i> <i>and</i> <i>colon</i> <i>and</i> <i>rectum</i> <i>and</i> <i>anus</i> <i>and</i> <i>perineum</i> <i>and</i> <i>scrotum</i> <i>and</i> <i>penis</i> <i>and</i> <i>testes</i> <i>and</i> <i>epididymis</i> <i>and</i> <i>prostate</i> <i>and</i> <i>bladder</i> <i>and</i> <i>ureters</i> <i>and</i> <i>kidneys</i> <i>and</i> <i>pancreas</i> <i>and</i> <i>spleen</i> <i>and</i> <i>liver</i> <i>and</i> <i>stomach</i> <i>and</i> <i>intestines</i> <i>and</i> <i>colon</i> <i>and</i> <i>rectum</i> <i>and</i> <i>anus</i> <i>and</i> <i>perineum</i> <i>and</i> <i>scrotum</i> <i>and</i> <i>penis</i> <i>and</i> <i>testes</i> <i>and</i> <i>epididymis</i> <i>and</i> <i>prostate</i> <i>and</i> <i>bladder</i> <i>and</i> <i>ureters</i> <i>and</i> <i>kidneys</i> <i>and</i> <i>pancreas</i> <i>and</i> <i>spleen</i> <i>and</i> <i>liver</i> <i>and</i> <i>stomach</i> <i>and</i> <i>intestines</i> <i>and</i> <i>colon</i> <i>and</i> <i>rectum</i> <i>and</i> <i>anus</i> <i>and</i> <i>perineum</i> <i>and</i> <i>scrotum</i> <i>and</i> <i>penis</i> <i>and</i> <i>testes</i> <i>and</i> <i>epididymis</i> <i>and</i> <i>prostate</i> <i>and</i> <i>bladder</i> <i>and</i> <i>ureters</i> <i>and</i> <i>kidneys</i> <i>and</i> <i>pancreas</i> <i>and</i> <i>spleen</i> <i>and</i> <i>liver</i> <i>and</i> <i>stomach</i> <i>and</i> <i>intestines</i> <i>and</i> <i>colon</i> <i>and</i> <i>rectum</i> <i>and</i> <i>anus</i> <i>and</i> <i>perineum</i> <i>and</i> <i>scrotum</i> <i>and</i> <i>penis</i> <i>and</i> <i>testes</i> <i>and</i> <i>epididymis</i> <i>and</i> <i>prostate</i> <i>and</i> <i>bladder</i> <i>and</i> <i>ureters</i> <i>and</i> <i>kidneys</i> <i>and</i> <i>pancreas</i> <i>and</i> <i>spleen</i> <i>and</i> <i>liver</i> <i>and</i> <i>stomach</i> <i>and</i> <i>intestines</i> <i>and</i> 									



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 11871</u>	
BIRTH NO. <u>3-220</u>				72 11871	
CERTIFICATE OF DEATH				STATE OF MARYLAND-DEME	
1. NAME OF DECEASED (Type or Print) <u>Harry Sachs</u>			2. DATE AND HOUR OF DEATH <u>Mar. 11, 1972</u> <u>6 37</u> a.m.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Sinai Hospital of Baltimore</u>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2717</u>		
			C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>2500 W. Belvedere Ave., APT. 711</u>		
5. SEX <u>MALE</u>	6. RACE <u>XX WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 7, 1896</u>	9. AGE (In years last birthday) <u>76</u>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CUTTER</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>CLOTHING</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>BENJAMIN SACHS</u>		
14. MOTHER'S MAIDEN NAME <u>YETTA ?</u>			15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		
16. SOCIAL SECURITY NO. <u>213-09-4846</u>			17. INFORMANT <u>MRS. BESSIE SACHS, 2500 W. BELVEDERE AVENUE</u>		
18. <u>514X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Pulmonary edema</u> DUE TO, OR AS A CONSEQUENCE OF:  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, lomo, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) <u>this hospital</u> attended the deceased from <u>Mar. 2</u> 19 <u>72</u> to <u>Mar. 12</u> 19 <u>72</u> that (1) <u>(we)</u> last saw the deceased alive on <u>Mar. 12</u> 19 <u>72</u> and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. (1) <u>(We)</u> (did) (did not) view the body after death.					
23A. SIGNATURE <u>Santos A. Uy, Jr.</u>				23B. DATE SIGNED <u>Mar. 12 / 72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Santos A. Uy, Jr.</u>				23D. ADDRESS <u>Sinai Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>12/12/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>ANSHE EMUNAH</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 15 1972</u>		25B. NAME OF REGISTRAR <u>Alvin J. ...</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</u>	

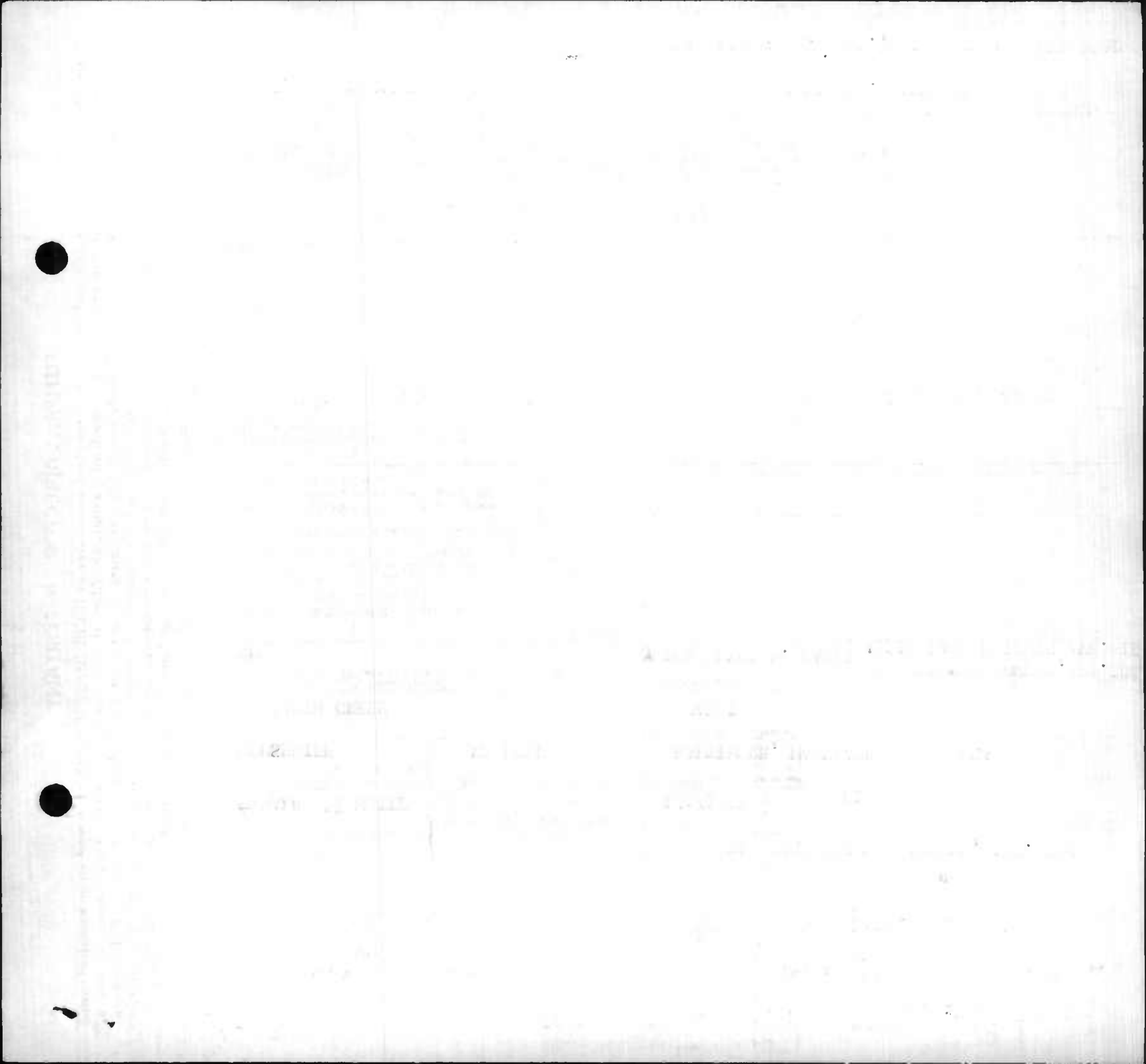




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 11872</b>
<b>C-635</b> <b>72 11872</b> <b>CERTIFICATE OF DEATH</b>		<b>STATE OF MARYLAND-DEATH</b>		
<b>1. NAME OF DECEASED</b> (Type or Print) <b>GREEN DORA CARDIN</b>		<b>2. DATE AND HOUR OF DEATH</b> <b>Dec 11, 1972 11:20 A.M.</b>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b> <b>SINAI HOSPITAL of BALTIMORE</b> <b>42</b>		<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) A. STATE <b>XXXXXXXXXXXXXXXXXXXXXXXXXX MARYLAND 2720</b> B. COUNTY <b>5. CITY OR TOWN</b> <b>Baltimore</b> <b>6. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>7. STREET AND NUMBER</b> <b>6210 PARK HEIGHTS AVENUE, APT. 704</b>		
<b>5. SEX</b> <b>FEMALE</b>	<b>6. RACE</b> <b>XX WHITE</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>1/2/1911</b>	
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>AT HOME</b>		<b>9. AGE</b> (In years last birthday) <b>61</b>
<b>11. BIRTHPLACE</b> (State or foreign country) <b>BALTIMORE, MARYLAND</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>		
<b>13. FATHER'S NAME</b> <b>BENJAMIN GREEN</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>RAE ?</b>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <b>JUDGE MEYER M. CARDIN</b>
		<b>ADDRESS</b> <b>STRATHMORE TOWERS, APT. 704</b> <b>6210 PARK HEIGHTS AVE. #15</b>		
<b>18. CAUSE OF DEATH</b> <b>410.91</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> <b>MYOCARDIAL INFARCTION</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> <b>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</b> <b>A.S.C.V.D.</b> <b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b> <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <b>2 wks</b>				
<b>19A. DATE OF OPERATION</b> <b>0</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY? (Yes or No)</b> <b>NO</b>
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)
<b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <b>Nov 28</b> <b>1972</b> <b>to</b> <b>Dec 11</b> <b>1972</b> <b>that (I) (we) last saw the deceased alive on</b> <b>Dec 11</b> <b>1972</b> <b>and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>				
<b>23A. SIGNATURE</b> <b>Hector Lopez Jr. MD.</b>		<b>23B. DATE SIGNED</b> <b>Dec 11, 1972</b>		<b>23C. PHYSICIAN'S NAME (Type)</b> <b>HECTOR LOPEZ JR. MD.</b>
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>		<b>24B. DATE</b> <b>12/12/72</b>		<b>24C. NAME OF CEMETERY OR CREMATORY</b> <b>BETH TFILOH</b>
<b>24D. LOCATION</b> (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>DEC 15 1972</b>		
<b>25B. NAME OF REGISTRAR</b> <b>Shirley Johnson</b>		<b>25C. FUNERAL DIRECTOR</b> <b>SO. LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>		



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 11873		72 11873	
BIRTH NO. <span style="font-size: 1.5em;">B-620</span>				72 11873		72 11873	
CERTIFICATE OF DEATH				REG. NO. <span style="font-size: 1.5em;">72 11873</span>		STATE OF MARYLAND - DEPT. OF HEALTH	
1. NAME OF DECEASED (Type or Print) <b>JEANETTE BROOKS</b>				2. DATE AND HOUR OF DEATH <b>12/10/72 10.32 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 2em;">33</span> <b>THE JOHNS HOPKINS HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN <b>PIKESVILLE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>7939 STEVENSON LANE ROAD #21208</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/22/93</b>	9. AGE (In years last birthday) <b>79</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HYMAN HORWITZ</b>				14. MOTHER'S MAIDEN NAME <b>LIBBY MULLEN</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-52-4341</b>		17. INFORMANT ADDRESS <b>MR. ALLEN M. BROOKS, 3414 MIDFIELD RD. #8</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>4/12/41</b> <b>CAUSE OF DEATH</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(A) IMMEDIATE CAUSE <i>Cardiorespiratory arrest</i> DUE TO, OR AS A CONSEQUENCE OF:							
(B) <i>Cardiogenic shock</i> DUE TO, OR AS A CONSEQUENCE OF:							
(C) <i>Arterio-sclerotic Cardio-vascular disease</i>							
<b>II</b>							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>12/7/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Epicardial Pacemaker Placement</b>		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>12/6</b> 19 <b>72</b> to <b>12/10</b> 19 <b>72</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>12/10</b> 19 <b>72</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>We</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.							
23A. SIGNATURE <i>Nelda Park Wray M.D.</i>				23B. DATE SIGNED <b>12/10/72</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) <b>NELDA PARK WRAY, M.D.</b>				23D. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12/12/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>AITZ CHAIM,</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 15 1972</b>		25B. NAME OF REGISTRAR <i>A. J. ...</i>		25C. FUNERAL DIRECTOR ADDRESS <b>SOL REVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>			

RECEIVED  
GENERAL  
THE GOVERNMENT

RECEIVED  
GENERAL  
THE GOVERNMENT

RECEIVED  
GENERAL  
THE GOVERNMENT

RECEIVED  
GENERAL  
THE GOVERNMENT

RECEIVED  
GENERAL  
THE GOVERNMENT

RECEIVED  
GENERAL  
THE GOVERNMENT

RECEIVED  
GENERAL  
THE GOVERNMENT

RECEIVED  
GENERAL  
THE GOVERNMENT

RECEIVED  
GENERAL  
THE GOVERNMENT

RECEIVED  
GENERAL  
THE GOVERNMENT

RECEIVED  
GENERAL  
THE GOVERNMENT

RECEIVED  
GENERAL  
THE GOVERNMENT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 11874	
U-162 72 11874				CERTIFICATE OF DEATH	
BIRTH NO. 4-162		1. NAME OF DECEASED (Type or Print) <u>Barney Dfberg</u>		2. DATE AND HOUR OF DEATH <u>Dec. 12, 1972 10 20 p.m.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2719</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Sinai Hospital of Baltimore, Inc.</u>				C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>3209 GLEN AVENUE</u>					
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/10/1979</u>	9. AGE (In years last birthday) <u>93</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PROPRIETOR</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>BODY &amp; FENDER REPAIR</u>		11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>MORRIS UFBERG</u>				14. MOTHER'S MAIDEN NAME <u>HANNAH ?</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>207-16-1274</u>		17. INFORMANT ADDRESS <u>MRS. MAE STARK, 5918 SIMMONDS AVE. #21215</u>	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cerebro Vascular Accident</u>					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>2 mos.</u>					
(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiovascular</u>					
(C) <u>Arteriosclerotic Heart Disease</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Dec. 7</u> 19 <u>72</u> to <u>Dec. 10</u> 19 <u>72</u> that (I) (we) lost saw the deceased alive on <u>Dec. 10</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Santos A. Dy, Jr. M.D.</u>				23B. DATE SIGNED <u>Dec. 12/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Santos A. Dy, Jr. M.D.</u>				23D. ADDRESS <u>Sinai Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>12/12/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>KEHILLIAT ISRAEL</u>	
24D. LOCATION (City, town, or county) (State) <u>SHENANDOAH, PENNSYLVANIA</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 15 1972</u>		25B. NAME OF REGISTRAR <u>Sidney Levinson</u>		25C. FUNERAL DIRECTOR ADDRESS <u>502 LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</u>	

OFFICE OF THE

SECRETARY

SECRET



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.			BIRTH DATE			BIRTH PLACE			BIRTH TIME		
5-552			72 11875			BALTIMORE CITY HEALTH DEPARTMENT			72 11875		
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH			REG. NO.			STATE OF MARYLAND - DEPT. OF HEALTH		
William Simmons			11 Dec 1972			730 PM					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)								
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE			B. COUNTY					
Sinai Hospital			MARYLAND								
			C. CITY OR TOWN			D. INSIDE CITY LIMITS?					
			BALTIMORE			YES <input type="checkbox"/> NO <input type="checkbox"/>					
			E. STREET AND NUMBER								
			4011 ROSECREST AVENUE #21215								
5. SEX			6. RACE			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>			8. DATE OF BIRTH		
MALE			WHITE			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9/XX/97		
9. AGE (In years last birthday)			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
75			SALESMAN			RUSSIA			USA		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME								
SOLOMON SIMMONS			SARAH ?								
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
YES W.W. I ARMY						MRS. TENIE FREEDMAN, 3 RUSSERN CT., APT. 1B #15					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:								
ANTECEDENT CAUSES			(B) DUE TO, OR AS A CONSEQUENCE OF:								
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) DUE TO, OR AS A CONSEQUENCE OF:								
II											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
11/25/72			Urinary retention								
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 14 Nov 1972 to 11 Dec 1972, that (I) (we) last saw the deceased alive on 11 Dec 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE			23B. DATE SIGNED								
Karen M. Lichtenfeld MD			11 Dec 1972								
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS								
Karen M. Lichtenfeld MD			Sinai Hosp.								
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE			24C. NAME OF CEMETERY or CREMATORY			24D. LOCATION (City, town, or county) (State)		
BURIAL			12/13/72			MOSES MONTIFIORE			BALTIMORE, MARYLAND		
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR			25C. FUNERAL DIRECTOR			ADDRESS		
DEC 15 1972			A. Simmons			SO. LEVINSON & BROS., 6010 REISTERSTOWN ROAD					

1907

1907

1907

1907

1907

1907

1907

1907

1907

1907

1907

1907

1907

1907

1907

1907

1907

1907

1907

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 11876</u>
M-240 72 11876		CERTIFICATE OF DEATH		
BIRTH NO. <u>1</u>		DEATH OF MARYLAND DEPT		
1. NAME OF DECEASED (Type or Print) <u>SIDNEY MAISEL</u>		2. DATE AND HOUR OF DEATH <u>12 / 12 / 72</u> <u>5</u> <u>A</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>SINAI HOSPITAL OF BALTO.</u> <u>42</u>		A. STATE <u>MD.</u> B. COUNTY <u>2831</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <u>4252 LABYRINTH RD BALTO 2215</u>		
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/10/07</u>	9. AGE (In years lost birthday) <u>65</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>RETAIL</u>	11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>SAMUEL MAISEL</u>		14. MOTHER'S MAIDEN NAME <u>ISA ?</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	17. INFORMANT <u>MRS. LENA MAISEL, 4252 LABYRINTH RD. #21215</u>	
18. <u>53111</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>CAUSE OF DEATH</u> <u>necrotizing, chemical pneumonia</u> <u>Aspiration pneumonia</u> <u>Paracatitiss, acute</u> <u>Perforating ulcer</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u> <u>12 days</u> <u>12 days</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>None</u>		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>no</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Nov 30</u> 19 <u>72</u> to <u>Dec 12</u> 19 <u>72</u> , that (I) (we) lost saw the deceased alive on <u>Dec 12</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Manuel Levin M.D.</u>			23B. DATE SIGNED <u>12/12/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>MANUEL LEVIN</u>			23D. ADDRESS <u>M.O. 6101 PARK HTS AVE, BALTO MD 21215</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>12/13/1972</u>	24C. NAME OF CEMETERY or CREMATORY <u>CHIZUK AMUNO (ARLINGTON)</u>	24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 15 1972</u>		25B. NAME OF REGISTRAR <u>Sidney Houston</u>	25C. FUNERAL DIRECTOR <u>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</u>	

THE UNIVERSITY OF CHICAGO PRESS

THE UNIVERSITY OF CHICAGO PRESS

THE UNIVERSITY OF CHICAGO PRESS

THE UNIVERSITY OF CHICAGO PRESS

THE UNIVERSITY OF CHICAGO PRESS

THE UNIVERSITY OF CHICAGO PRESS

THE UNIVERSITY OF CHICAGO PRESS

THE UNIVERSITY OF CHICAGO PRESS

THE UNIVERSITY OF CHICAGO PRESS

THE UNIVERSITY OF CHICAGO PRESS

THE UNIVERSITY OF CHICAGO PRESS

THE UNIVERSITY OF CHICAGO PRESS

THE UNIVERSITY OF CHICAGO PRESS

THE UNIVERSITY OF CHICAGO PRESS

THE UNIVERSITY OF CHICAGO PRESS

THE UNIVERSITY OF CHICAGO PRESS

THE UNIVERSITY OF CHICAGO PRESS

THE UNIVERSITY OF CHICAGO PRESS

THE UNIVERSITY OF CHICAGO PRESS

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) DINA COHEN		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1636 Harford Avenue		3. DATE PRONOUNCED DEAD Month Day Year Hour December 11, 1972 12:10 P. M.	
6. SEX Female		7. RACE White	
8. MARried <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
9. DATE OF BIRTH 10. AGE (in years last birthday) 81 XXX		E. STREET AND NUMBER 1636 Harford Avenue	
11. BIRTHPLACE (State or foreign country) LITHUANIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HARRY SACHS		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	
15. MOTHER'S MAIDEN NAME sarah ?		16. KIND OF BUSINESS OR INDUSTRY AT HOME	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		18. SOCIAL SECURITY NO.	
19. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		19. CAUSE OF DEATH Arteriosclerotic cardiovascular disease	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/12/72	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/13/72	
24C. NAME OF CEMETERY or CREMATORY ADATH YESHURUN (SODOVA)		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1972		25B. NAME OF REGISTRAR Sidney [Signature]	
25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		ADDRESS	

SECTION 10

FOR RECORD

DATE

TIME

LOCATION

REMARKS

NO.

NAME

AGE

SEX

REL.

EDUC.

STATUS

NO.

NAME

AGE

SEX

REL.

EDUC.

STATUS

NO.

NAME

AGE

SEX

REL.

EDUC.

STATUS

NO.

NAME

AGE

SEX

REL.

EDUC.

STATUS

NO.

NAME

AGE

SEX

REL.

EDUC.

STATUS

NO.

NAME

AGE

SEX

REL.

EDUC.

STATUS

NO.

NAME

AGE

SEX

REL.

EDUC.

STATUS

NO.

NAME

AGE

SEX

REL.

EDUC.

STATUS

NO.

NAME

AGE

SEX

REL.

EDUC.

STATUS

NO.

NAME

AGE

SEX

REL.

EDUC.

STATUS

NO.

NAME

AGE

SEX

REL.

EDUC.

STATUS

NO.

NAME

AGE

SEX

REL.

EDUC.

STATUS

NO.

NAME

AGE

SEX

REL.

EDUC.

STATUS

NO.

NAME

AGE

SEX

REL.

EDUC.

STATUS

NO.

NAME

AGE

SEX

REL.

EDUC.

STATUS

NO.

NAME

AGE

SEX

REL.

EDUC.

STATUS

NO.

NAME

AGE

SEX

REL.

EDUC.

STATUS

NO.

NAME

AGE

SEX

REL.

EDUC.

STATUS

NO.

NAME

AGE

SEX

REL.

EDUC.

STATUS

NO.

NAME

AGE

SEX

REL.

EDUC.

STATUS

NO.

NAME

AGE

SEX

REL.

EDUC.

STATUS

NO.

NAME

AGE

SEX

REL.

EDUC.

STATUS

NO.

NAME

AGE

SEX

REL.

EDUC.

STATUS

NO.

NAME

AGE

SEX

REL.

EDUC.

STATUS

NO.

NAME

AGE

SEX

REL.

EDUC.

STATUS

NO.

NAME

AGE

SEX

REL.

EDUC.

STATUS

NO.

NAME

AGE

SEX

REL.

EDUC.

STATUS

NO.

NAME

AGE

SEX

REL.

EDUC.

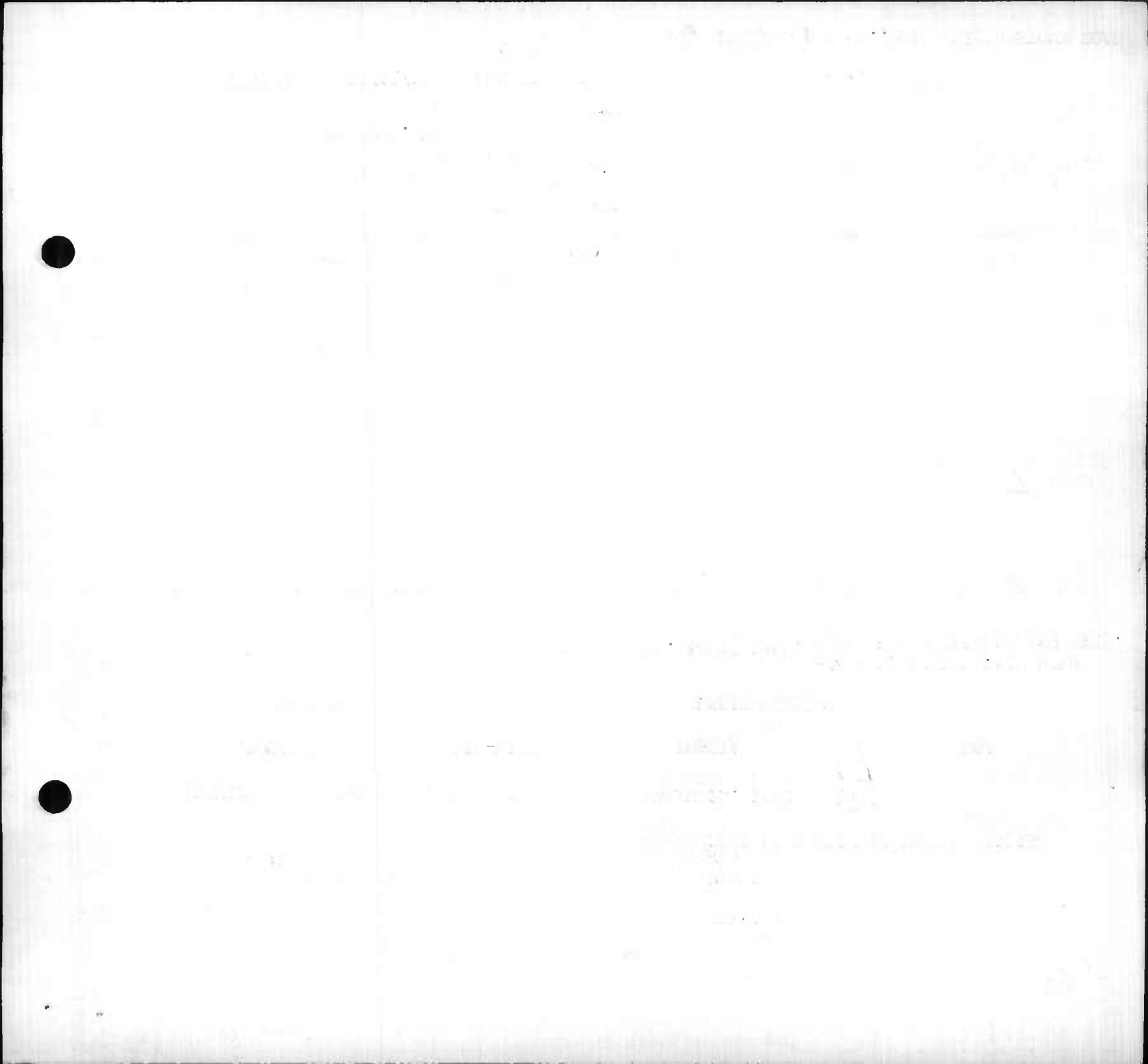
STATUS



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 11878		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 11878	
M-625		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Mapenson, Ada</i>		2. DATE AND HOUR OF DEATH <i>Dec. 10 1972 8:45 P.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <i>LEVINDALE AGED HOME</i>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <i>MARYLA ND</i> B. COUNTY <i>1512</i>		C. CITY OR TOWN <i>BALTIMORE</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>FEMALE</i>		6. RACE <i>WHITE</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>MARCH 15, 1892</i>		9. AGE (In years last birthday) <i>80</i>		10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RETIRED</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>MID-WIFE</i>		11. BIRTHPLACE (State or foreign country) <i>RUSSIA</i>	
13. FATHER'S NAME <i>MORRIS HUSS</i>		14. MOTHER'S MAIDEN NAME <i>ESSIE EHRLOCK</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>NO</i>		17. INFORMANT <i>MR. LOUIS BALK, c/o LEVINDALE HEBREW HOME</i> ADDRESS <i>BELVEDERE &amp; GREENSPRING AVES.</i>	
18. <i>4/12/71</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Congestive Heart Failure</i> (B) <i>ASCVD</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Cerebral Thrombosis</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 hrs.</i> <i>XRS.</i> <i>7 mos.</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>the</del> (this hospital) attended the deceased from <i>5/30</i> 19 <i>72</i> to <i>12/10</i> 19 <i>72</i> that <del>we</del> (we) last saw the deceased alive on <i>12/10</i> 19 <i>72</i> and that <del>in</del> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE <i>Robert L. Young MD</i>		23B. DATE SIGNED <i>12/10/72</i>		23C. PHYSICIAN'S NAME (Type) <i>ROBERT L. YOUNG</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>12/12/72</i>		24C. NAME of CEMETERY or CREMATORY <i>SHOMRA ADATH</i>	
24D. LOCATION (City, town, or county) <i>ROSEDALE, MARYLAND</i>		25A. DATE REC'D BY HEALTH DEPT. <i>DEC 15 1972</i>			
25B. NAME OF REGISTRAR <i>Friday, 12/10/72</i>		25C. FUNERAL DIRECTOR <i>SQL LEVINSON &amp; BROS.</i> ADDRESS <i>6010 REISTERSTOWN ROAD</i>			





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 11879

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MORRIS CAPLAN

2. DATE  
OF  
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF  
HOSPITAL  
OR INSTITUTION  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Lutheran Hospital

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

12

10

1972

11:45p

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Md.

B. COUNTY Balto.

Balto.

6. SEX

male

7. RACE

white

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

JANUARY 25, 1904

10. AGE (In years  
lost birthday)

68

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

2825 MARYLAND AVE. MARNAT ROAD

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?  
USA

13. FATHER'S NAME

BENJAMIN CAPLAN

14. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

CHAUFFEUR

14B. KIND OF BUSINESS OR INDUSTRY

DIAMOND CAB

15. MOTHER'S MAIDEN NAME

GOLDIE ?

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

YES

W.W. II

17. SOCIAL  
SECURITY NO.

218-22-5109

18. INFORMANT

ADDRESS

MRS. KITTY CAPLAN, 2825 MARNAT ROAD #21209

19.

E 812.0

CAUSE OF DEATH

Massive pneumonia

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) multiple injuries

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A)

20A. DATE OF OPERATION

1

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)  
yes22A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)

road

22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?2400 BIR. Edmondson Ave. at  
intersection of Warwick22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.) 11-14-72

5a

22E. INJURY OCCURRED

WHILE AT  
WORK ☒NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

Driver of cab in auto-auto accident.

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Peter Lipkovic, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-11-72

24A. BURIAL CREMATION,  
REMOVAL (Specify)  
BURIAL

24B. DATE

12/12/72

24C. NAME of CEMETERY or CREMATORY

SHIAAREI ZION

24D. LOCATION

(City, town, or county)

(State)

ROSEDALE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.

DEC 15 1972

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD

UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT

WATER RESOURCES DIVISION  
SALT LAKE CITY, UTAH  
OFFICE OF THE DISTRICT ENGINEER  
SALT LAKE CITY, UTAH

TO: DISTRICT ENGINEER, SALT LAKE CITY  
FROM: DISTRICT ENGINEER, SALT LAKE CITY  
SUBJECT: [Illegible]

DATE: [Illegible]  
RE: [Illegible]

[Illegible text block]

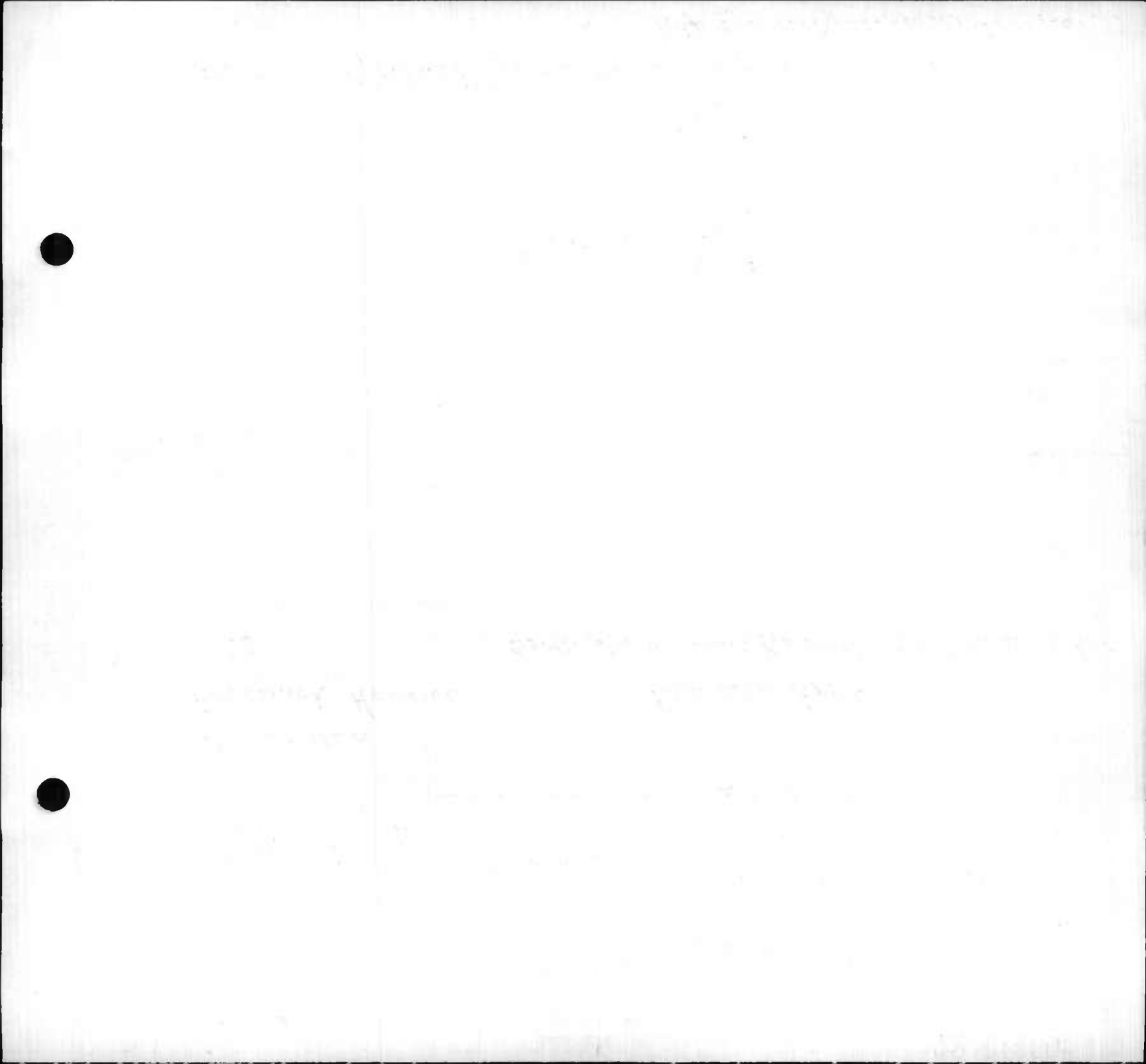
[Illegible text block]

[Illegible text block]

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-200		72 11880		BALTIMORE CITY HEALTH DEPARTMENT		72 11880	
CERTIFICATE OF DEATH				REG. NO. STATE OF MARYLAND-DEME			
1. NAME OF DECEASED (Type or Print) <b>KAWECKI, MRS. MYRTLE</b>				2. DATE AND HOUR OF DEATH <b>12-12-1972 7:15 PM</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>35 Church Home &amp; Hospital Baltimore MD.</b>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>103</b>			
				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>711 S. LUZERNE Ave 21224.</b>			
5. SEX <b>F</b>	6. RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-22-1898</b>	9. AGE (In years last birthday) <b>74</b>	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MD.</b>	
13. FATHER'S NAME <b>FREDERICK HENNING</b>				14. MOTHER'S MAIDEN NAME <b>ELIZABETH APPEL</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>212-42-7676</b>		17. INFORMANT <b>MR. LOUIS KAWECKI</b>	
				ADDRESS <b>711 S. LUZERNE AVE</b>			
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cardiac Arrest.</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Myocardial Infarction.</b> <b>Cerebrovascular Accident.</b>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>12/4/1972</b> to <b>12/12/1972</b> that (I) (we) last saw the deceased alive on <b>12/12/1972</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>M. Yousuf Siddiqui MD</b>				23B. DATE SIGNED <b>12/12/72</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) <b>M. YOUSUF SIDDIQUI MD</b>				23D. ADDRESS <b>Church Home &amp; Hosp 100 N. Broadway Balto MD 21231</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/16/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 15 1972</b>		25B. NAME OF REGISTRAR <b>Sidney...</b>		25C. FUNERAL DIRECTOR <b>KACZOROWSKI</b>		ADDRESS <b>2525 FLEET ST.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 11881	
W-325 72 11881				CERTIFICATE OF DEATH	
BIRTH NO.				STATE OF MARYLAND-DEATH	
1. NAME OF DECEASED (Type or Print) <b>WATSON, FANNIE</b>			2. DATE AND HOUR OF DEATH <b>12-12-72 9:00 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1503</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>46 LUTHERAN Hospital Baltimore, Md. 21216</b>			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <b>7</b> 6. RACE <b>B</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>8-9-98</b>		9. AGE (in years last birthday) <b>74</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>Dennis Barrington</b>			14. MOTHER'S MAIDEN NAME <b>Maragaret Barrington</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>220-12-4430</b>		17. INFORMANT <b>Foster Watson</b> ADDRESS <b>JAME</b>
18. <b>410.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <b>Acute Cardiorespiratory Arrest</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Acute myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Acute Congestive Heart Failure</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 min.</b>		
19A. DATE OF OPERATION <b>0</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>12/31</b> 19 <b>72</b> to <b>12/12/1972</b> that (I) (we) last saw the deceased alive on <b>12/12/1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>S-S. DONGRE</b>			23B. DATE SIGNED <b>12/14/72</b>		23C. PHYSICIAN'S NAME (Type) <b>S-S. DONGRE</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			24B. DATE <b>12/16/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>MD. NATIONAL MEM. PARK</b>
24D. LOCATION (City, town, or county) (State) <b>Laurel, MARYLAND</b>			25A. DATE REC'D BY HEALTH DEPT. <b>DEC 15 1972</b>		
25B. NAME OF REGISTRAR <b>William J. Spiew</b>			25C. FUNERAL DIRECTOR <b>1639 N. Broadway</b>		

RECEIVED  
JAN 10 1964

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

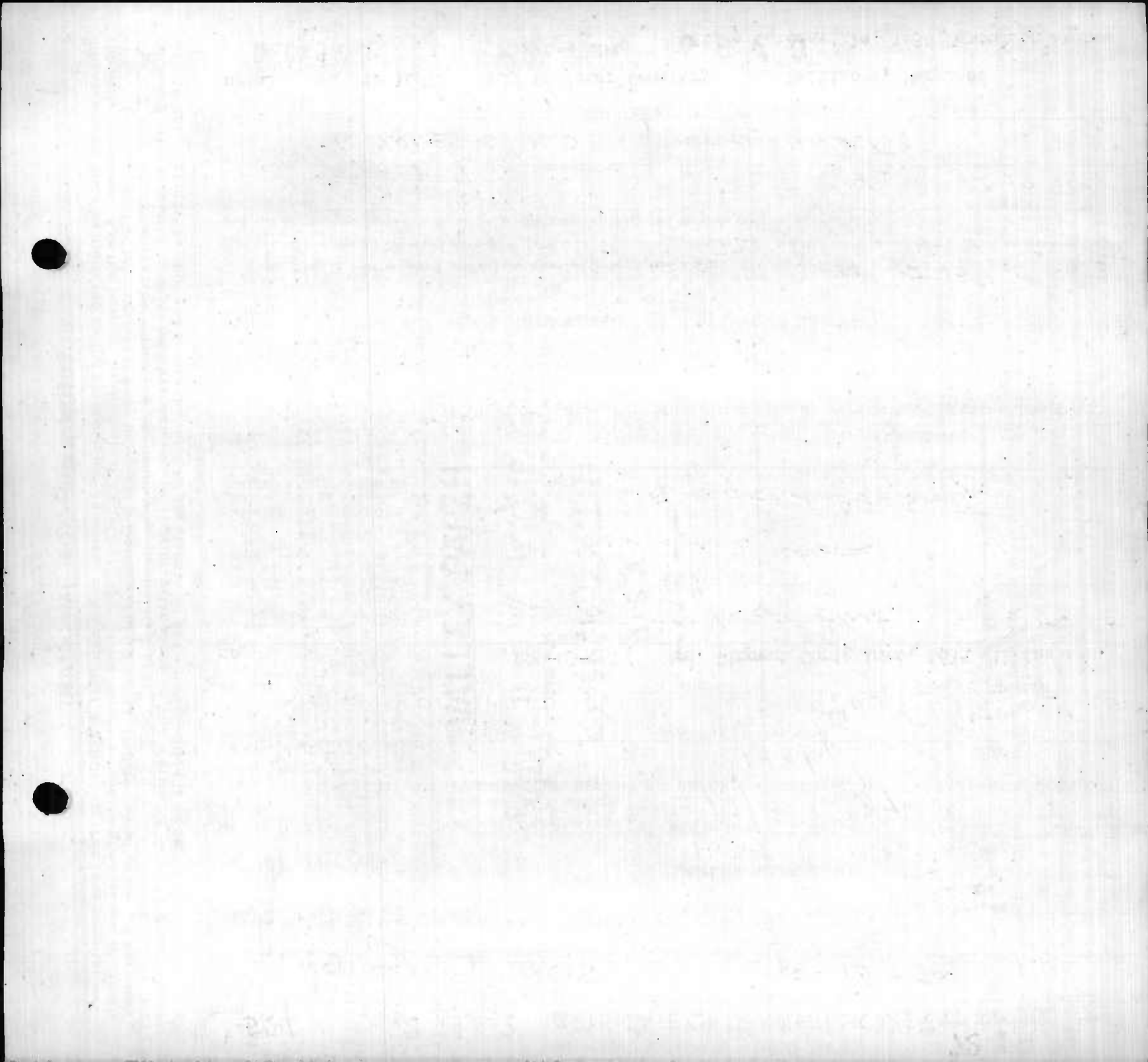
100-100000



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

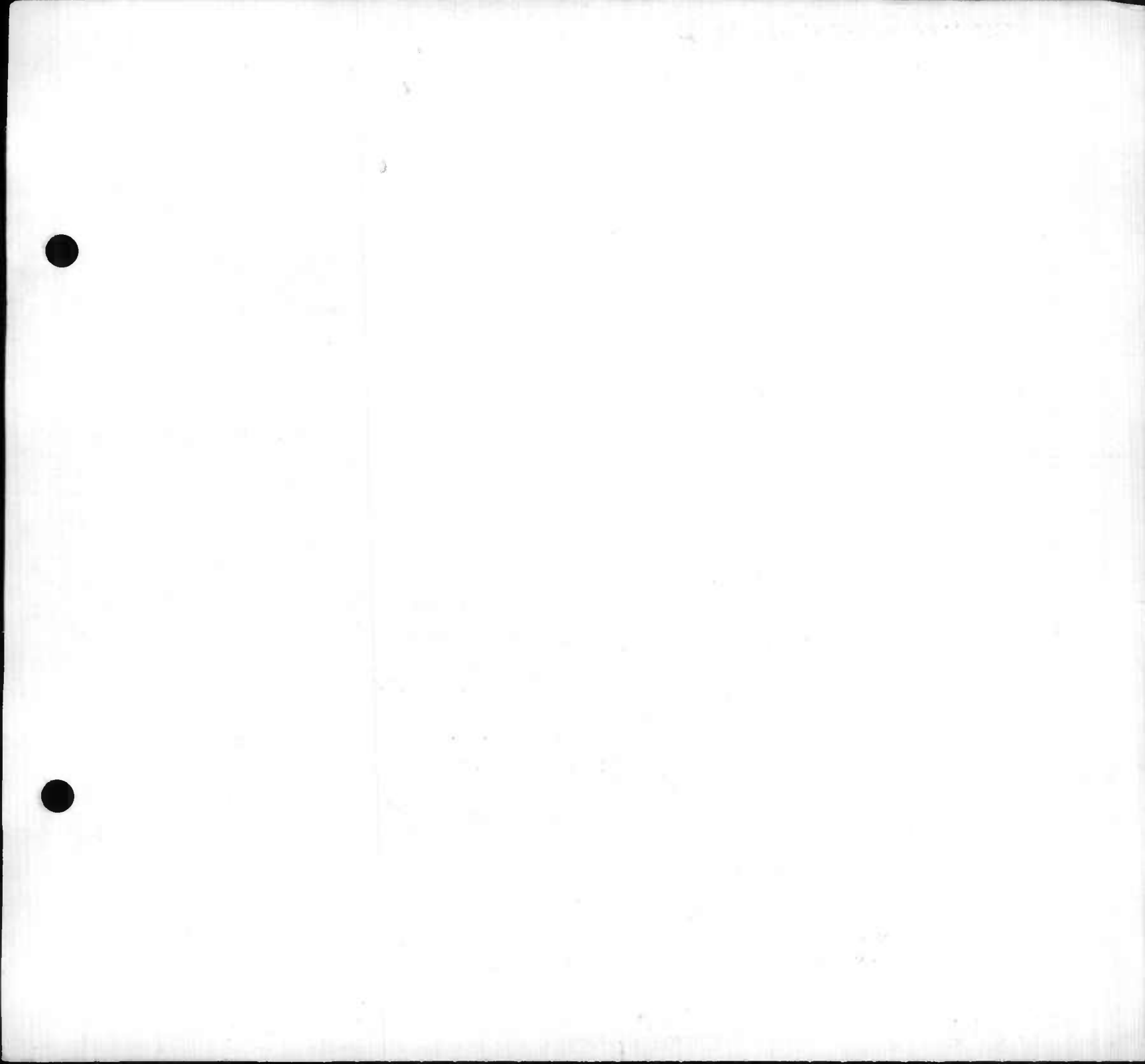
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">72 11882</span>	
C-524 72 11882				STATE OF MARYLAND-DHMH	
BIRTH NO.			BIRTH NO.		
1. NAME OF DECEASED (Type or Print) <b>Conigliaro, Vincent</b>			2. DATE AND HOUR OF DEATH <b>12-13-72</b> <span style="float: right;">P. M.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>md.</b> B. COUNTY <b>1903</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>37 Mercy</b>			C. CITY OR TOWN <b>Balto.</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <b>1635 Wilkens Ave.</b>		
5. SEX <b>m</b>	6. RACE <b>w</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/7/15</b>	9. AGE (In years last birthday) <b>57</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>construction worker</b>			11. BIRTHPLACE (State or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>John Conigliaro</b>			14. MOTHER'S MAIDEN NAME <b>Concetta Culotta</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>220-03-6679</b>		17. INFORMANT ADDRESS <b>Mrs. Vincent Conigliaro, 1635 Wilkens Ave.</b>
18. <b>410.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Complete heart block</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Cardiogenic shock</b> <b>acute myocardial infarction</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12-3</b> 19 <b>72</b> to <b>12-13</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>12-13</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>G. Vanegas M.D.</b>				23B. DATE SIGNED <b>12-13-72</b>	
23C. PHYSICIAN'S NAME (Type) <b>G. VANEGAS, M.D.</b>				23D. ADDRESS <b>Mercy Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/16/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 15 1972</b>			
25B. NAME OF REGISTRAR <b>Adrienne Johnson</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Witzke Catonsville, 1630 Edmondson Avenue</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 11883	
G-653 72 11883		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Grandy, Joseph H.</b>		2. DATE AND HOUR OF DEATH <b>12-13-72 5:10 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>Church Home &amp; Hospital</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Catonsville</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>35 Church Home &amp; Hospital</b>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>M</b> 6. RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Plumbing Supplies</b>	
13. FATHER'S NAME <b>Grandy, Joseph</b>		14. MOTHER'S MAIDEN NAME <b>Kraus, Eleanor</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>213-09-8713</b>	
17. INFORMANT <b>Mr. Joseph Grandy</b>		ADDRESS <b>1101 Dorchester Ave. Catonsville, Md.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cancer of the colon metastasizing to the liver</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>11-28</b> 19 <b>72</b> to <b>12-13</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>12-11</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Milton Kress, M.D.</b>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>MILTON KRESS, M.D.</b>		23D. ADDRESS <b>CHURCH HOME &amp; HOSPITAL BALTIMORE, Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/16/72</b>	
24C. NAME of CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 15 1972</b>		25B. NAME of REGISTRAR <b>Witzke</b>	
25C. FUNERAL DIRECTOR <b>Witzke</b>		ADDRESS <b>1630 Edmondson Ave., 21228</b>	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p><b>CERTIFICATE OF DEATH</b></p>		<p>REG. NO. <b>72 11884</b></p> <p><b>STATE OF MARYLAND-DEATH</b></p>	
<p>BIRTH NO. <b>H-655</b></p>		<p>72 11884</p>	
<p>1. NAME OF DECEASED (Type or Print) <b>HARMAN, GEORGE W.</b></p>		<p>2. DATE AND HOUR OF DEATH <b>Dec. 14, 1972 3:20 P.M.</b></p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>md.</b> B. COUNTY <b>md.</b></p>	
<p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>45 South Baltimore General Hosp. 3001 S. Hanover St. Balto, Md. 21230</b></p>		<p>C. CITY OR TOWN <b>Baltimore, 21230</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	
<p>E. STREET AND NUMBER <b>1708 Light St.</b></p>			
<p>5. SEX <b>M</b></p>	<p>6. RACE <b>W.</b></p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <del>WIDOWED</del> <b>DIVORCED <input checked="" type="checkbox"/></b></p>	<p>8. DATE OF BIRTH <b>7/4/92</b></p>
<p>9. AGE (In years last birthday) <b>80</b></p>		<p>If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.</p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. R.R. Conductor B&amp;O.R.R.</b></p>		<p>11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b></p>	
<p>12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b></p>			
<p>13. FATHER'S NAME <b>George W. HARMAN</b></p>		<p>14. MOTHER'S MAIDEN NAME <b>Amelia G. Hopp</b></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b></p>		<p>16. SOCIAL SECURITY NO. <b>705-05-3747</b></p>	
<p>17. INFORMANT <b>George W. HARMAN (Nephew)</b></p>		<p>ADDRESS <b>Baltimore 21227</b></p>	
<p>18. <b>481X I</b></p>		<p>CAUSE OF DEATH</p>	
<p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p>		<p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Acute Perforating ulcer</b></p>	
<p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>(B) CHRONIC Obstructive Airway disease (C) pt. lower lobe pneumonia, sepsis</p>	
<p><b>II</b></p>			
<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>			
<p>19A. DATE OF OPERATION</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No) <b>No</b></p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>			
<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	
<p>21F. HOW DID INJURY OCCUR?</p>			
<p>22. I certify that (I) (this hospital) attended the deceased from <b>Dec. 5, 1972</b> to <b>Dec. 14, 1972</b>, that (I) (we) last saw the deceased alive on <b>Dec. 14, 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <b>S. Fios, M.D.</b></p>		<p>23B. DATE SIGNED <b>Dec. 14, 72</b></p>	
<p>23C. PHYSICIAN'S NAME (Type) <b>FELIPE FIOS</b></p>		<p>23D. ADDRESS <b>3001 S. Hanover St. Balto. Md.</b></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b></p>		<p>24B. DATE <b>Dec. 16, 1972</b></p>	
<p>24C. NAME OF CEMETERY OR CREMATORY <b>West Hill Cemetery</b></p>		<p>24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b></p>	
<p>25A. DATE REC'D BY HEALTH DEPT. <b>DEC 15 1972</b></p>		<p>25B. NAME OF REGISTRAR <b>Adrian Johnson</b></p>	
<p>25C. FUNERAL DIRECTOR <b>CURTIS E. EVANS</b></p>		<p>ADDRESS <b>1400 S. Charles St. 21230</b></p>	

DEPT. OF THE ARMY  
OFFICE OF THE CHIEF OF ENGINEERS  
WASHINGTON, D. C.

TO: THE CHIEF OF ENGINEERS  
FROM: THE CHIEF OF ENGINEERS  
SUBJECT: [Illegible]

1. [Illegible]  
2. [Illegible]  
3. [Illegible]  
4. [Illegible]  
5. [Illegible]  
6. [Illegible]  
7. [Illegible]  
8. [Illegible]  
9. [Illegible]  
10. [Illegible]



72 11885		STATE OF MARYLAND-DEMH BALTIMORE CITY HEALTH DEPARTMENT		72 11885	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO.	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) IRVING PYE			2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.		
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 St. Agnes Hospital			3. DATE PRONOUNCED DEAD Month Day Year Hour 12 11 1972 12:42a M.		
6. SEX male			5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission) A. STATE Md. B. COUNTY 2006		
7. RACE negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH February 12, 55		10. AGE (In years last birthday) 17		E. STREET AND NUMBER 12 S. Abington St.	
11. BIRTHPLACE (State or foreign country) Baltimore, Md		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Robert Pye	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Elizabeth Madison	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS Elizabeth Anderson - 12. S. Abington Ave	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Gunshot wound of chest (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 3200 blk. Lohrs Lane 90' e. of Hilton	
22D. TIME OF INJURY (APPROX.) 12-11-72 12:31a m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Shot by assailant during robbery.	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <i>Ronald N. Kornblum</i> M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. DATE SIGNED 12-11-72					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-15-72		24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cemetery	
24D. LOCATION (City, town, or county) (State) A. A. Co.		25A. DATE REC'D BY HEALTH DEPT. DEC 15 1972			
25B. NAME OF REGISTRAR A. A. Co.		25C. FUNERAL DIRECTOR ADDRESS Arlington S. Phillips-1721-27 N. Monroe St			

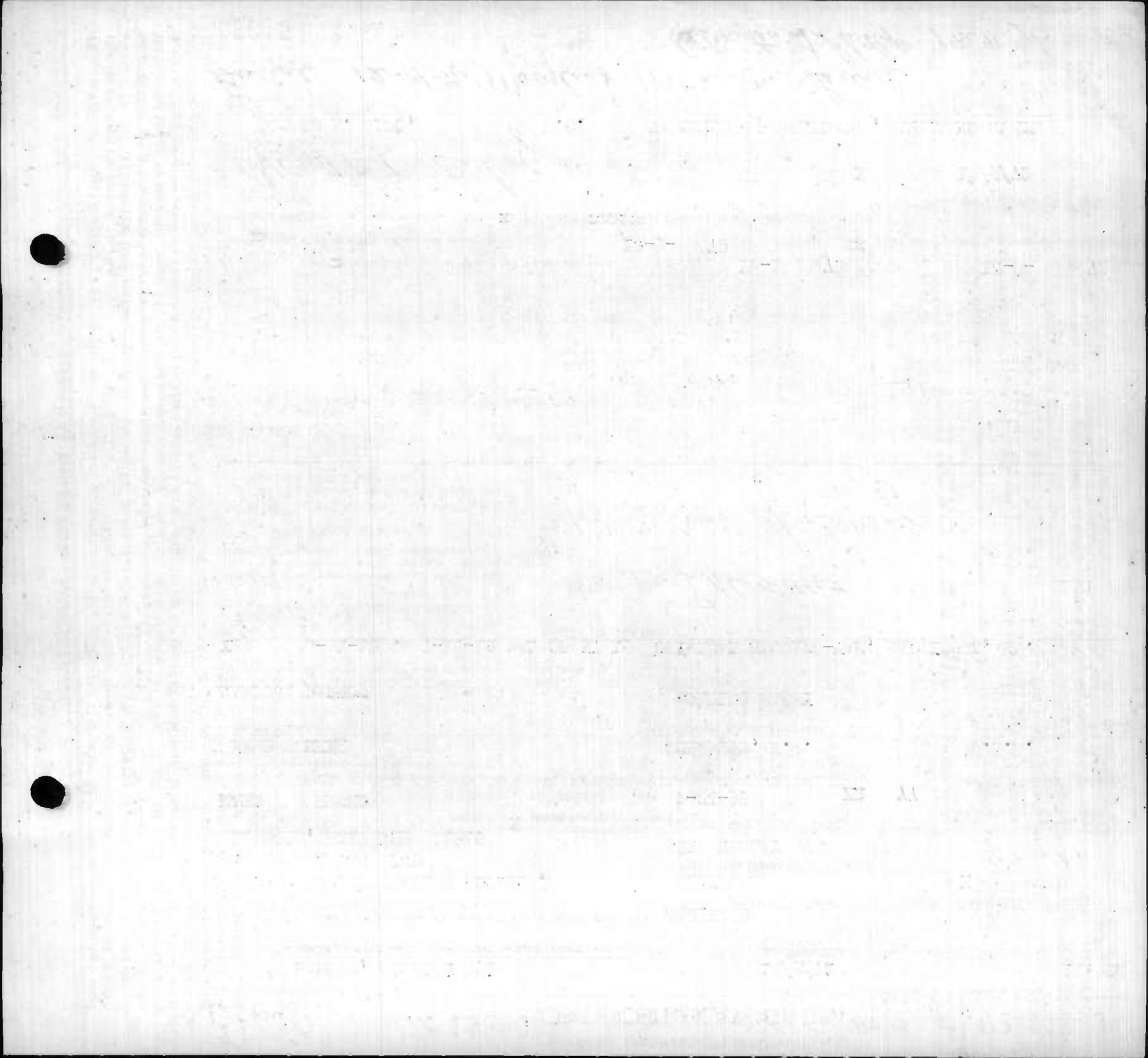




# FUNERAL DIRECTOR: IMPORTANT

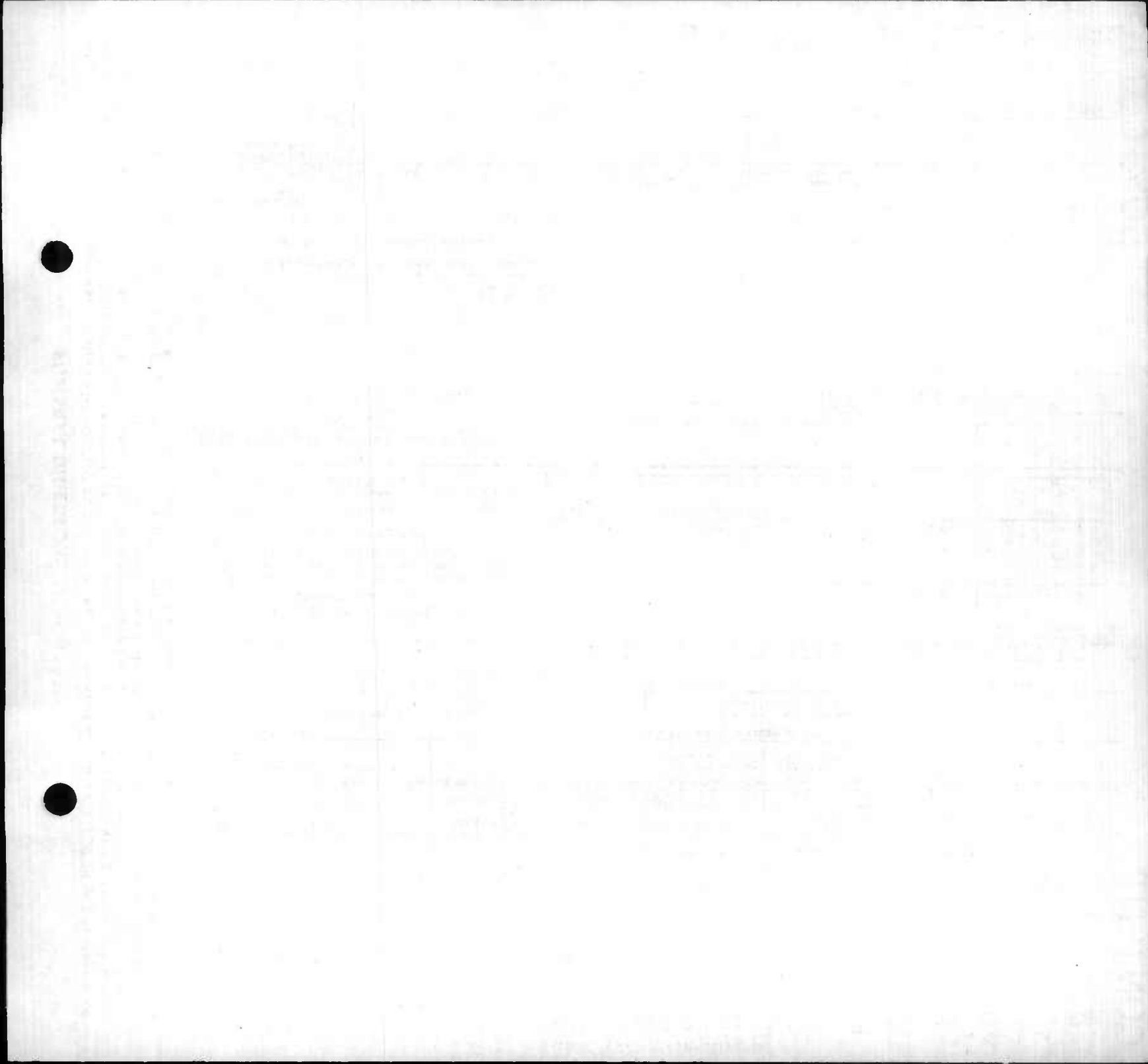
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-600		72 11886		BALTIMORE CITY HEALTH DEPARTMENT		72 11886	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) <b>BARROW, METTRAH NMI</b>				2. DATE AND HOUR OF DEATH <b>12/9/72 11:20A</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2802</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>VETERANS ADMINISTRATION HOSPITAL</b> <b>3900 LOCH RAVEN BLVD</b> <b>BALTIMORE, MARYLAND 21218</b>				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>MALE</b>		6. RACE <b>NEGRO</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-24-95</b>	
9. AGE (In years last birthday) <b>77</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LUMBER WORKER</b>		11. BIRTHPLACE (State or foreign country) <b>SCRANTON, N.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>SAMPSON BARROW</b>				14. MOTHER'S MAIDEN NAME <b>MORNING MACKY</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES</b>				16. SOCIAL SECURITY NO. <b>8-21-18 to 7-19-19 241 28 37 15</b>		17. INFORMANT ADDRESS <b>CLINICAL RECORDS-VAH, BALTIMORE, MD.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>162.1</b> <b>CAUSE OF DEATH</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(A) IMMEDIATE CAUSE <b>Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF:				(B) <b>Carcinoma of lung</b> DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____				(D) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				19A. DATE OF OPERATION <b>0</b>			
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>				20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>-</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>12-2 1972</b> to <b>12-9- 19 72</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>12-9- 19 72</b> and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <b>(not)</b> view the body after death.							
23A. SIGNATURE <b>Donald E. Klug</b>				23B. DATE SIGNED <b>12/9/72</b>		23C. PHYSICIAN'S NAME (Type) <b>DONALD E. KLUG, M.D.</b>	
23D. ADDRESS <b>VAHOSPITAL, BALTIMORE, MARYLAND 21218</b>				24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			
24B. DATE <b>12-14-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Maryland National</b>		24D. LOCATION (City, town, or county) (State) <b>Laurel MD</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 15 1972</b>	
25B. NAME OF REGISTRAR <b>Lidney</b>		25C. FUNERAL DIRECTOR <b>Shelly</b>		25D. ADDRESS <b>172 M. Mount St.</b>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

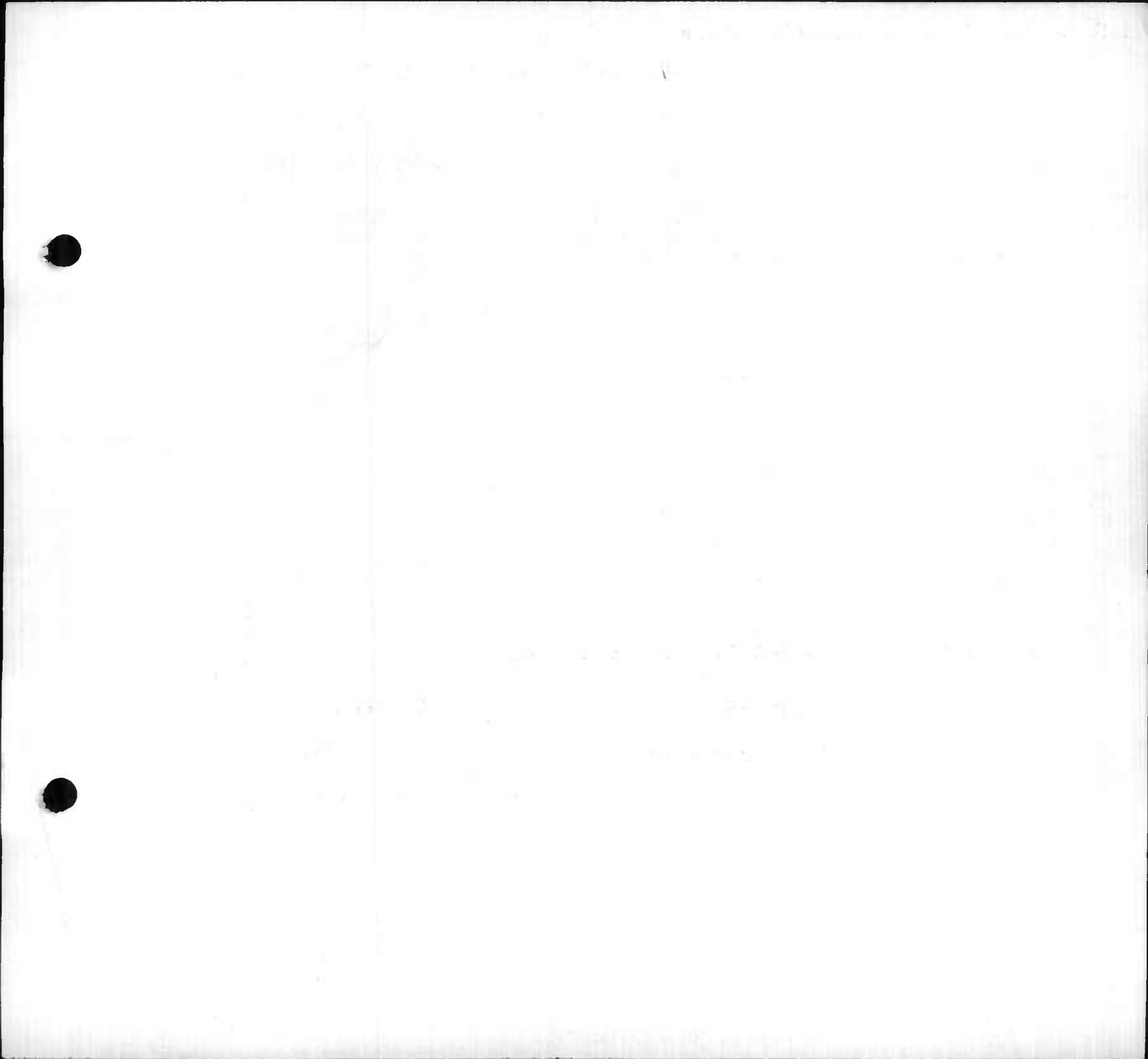
BIRTH NO. <b>G-620</b>		BALTIMORE CITY HEALTH DEPARTMENT		72 11887		REG. NO. <b>72 11887</b>	
1. NAME OF DECEASED (Type or Print) <b>Joseph Gross</b>				2. DATE AND HOUR OF DEATH <b>8 Dec 72 11/40/P</b> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>43 SOUTH BALTIMORE GENERAL</b>				A. STATE <b>MARYLAND</b> B. COUNTY <b>AA</b>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>279 Cecil Avenue - MILLERSVILLE, MD</b>							
5. SEX <b>MALE</b>	6. RACE <b>BLACK</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUGUST 13, 1905</b>	9. AGE (in years last birthday) <b>67</b>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CHAUFFER</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOSEPH B. GROSS</b>				14. MOTHER'S MAIDEN NAME <b>JULIA JENNEFER</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>212-09-3627A</b>		17. INFORMANT ADDRESS <b>DELMA GROSS 279 CECIL AVENUE - MILLERSVILLE, MD</b>			
18. <b>4-10-91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <b>Acute anterolateral myocardial infarct 4 hours.</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Arteriosclerotic cardiovascular disease 10 yrs</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Previous inferior myocardial infarct ? years.</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>(pending)</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>11-30</b> 19 <b>72</b> to <b>8 Dec</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>8 Dec 72</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Sidney R. Hubler MD</b>				23B. DATE SIGNED <b>8 Dec 72</b>		23C. PHYSICIAN'S NAME (Type) <b>Sidney R. Hubler MD</b>	
23D. ADDRESS <b>Argington S. Phillips-1721-27 N. Monroe St</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12-12-72</b>		24C. NAME of CEMETERY or CREMATORY <b>PINE LAWN MEMORIAL CEMETERY</b>		24D. LOCATION (City, town, or county) (State) <b>BESTGATE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 15 1972</b>		25B. NAME OF REGISTRAR <b>Sidney R. Hubler MD</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Argington S. Phillips-1721-27 N. Monroe St</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

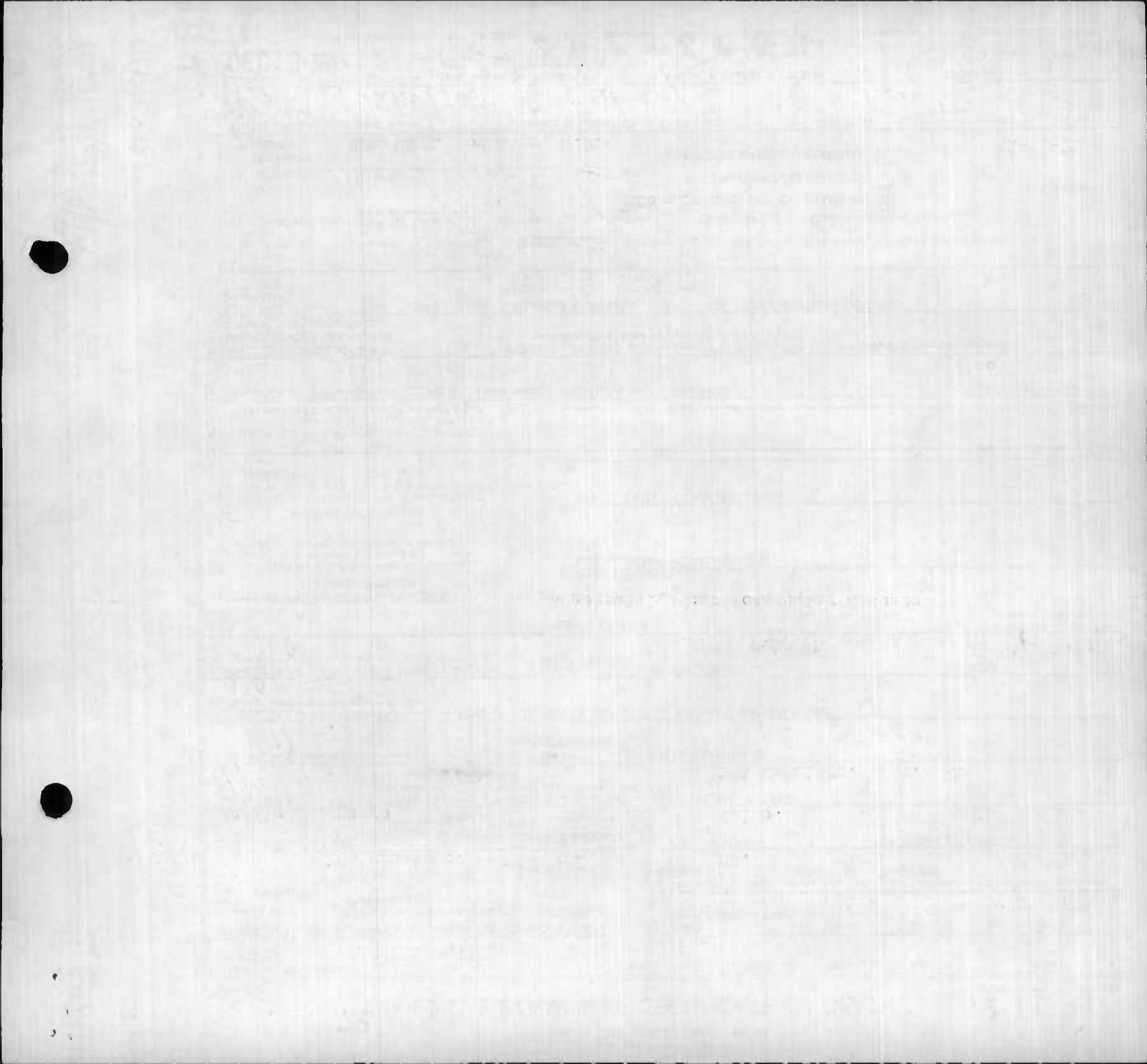
J-520		72 11888		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 11888	
BIRTH NO.				STATE OF MARYLAND - DHMH			
1. NAME OF DECEASED (Type or Print) JONES, EUGENIA				2. DATE AND HOUR OF DEATH 12-9-72 12:15 a.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 46 LUTHERAN HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MARYLAND B. COUNTY 1604			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1024 N. MONROE ST.			
5. SEX F	6. RACE Black	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/6/1880	9. AGE (In years last birthday) 92	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) St Mary's Co, Maryland	
13. FATHER'S NAME William Hill				14. MOTHER'S MAIDEN NAME Mary Hill			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-36-3097		17. INFORMANT John H. Carter		ADDRESS 1024 N. Monroe Street	
18. 436.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Cerebro Vascular Accident GASTROINTESTINAL Drowning				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month FEW hours			
19. 436.9 I DISEASES OR CONDITIONS, if any, giving rise to the above cause (At stating the UNDERLYING CONDITION last.) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from November 11 19 72 to December 9 19 72 that (I) (we) last saw the deceased alive on December 9 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Renato A. Labog M.D.				23B. DATE SIGNED 12/9/72			
23C. PHYSICIAN'S NAME (Type) RENATO A. LABOG, M.D.				23D. ADDRESS Lutheran Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-13-72		24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1972		25B. NAME OF REGISTRAR Sidney Johnson		25C. FUNERAL DIRECTOR Arlington S. Phillips		ADDRESS 1727 N. Monroe St 21217	





C-652 72 11889  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 72 11889

1. NAME OF DECEASED (Type or Print) PACOILA CRENSHAW		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1204 Canal Ct. APT A2		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 11 1972 8:20a M.	
6. SEX female		7. RACE negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 501	
9. DATE OF BIRTH 4/9/23		10. AGE (in years lost birthday) 49	
11. BIRTHPLACE (State or foreign country) N.C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME WILLIE MACK		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC	
15. MOTHER'S MAIDEN NAME ?		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO.		18. INFORMANT Leanne ROXIE 1204 Canal Ct. APT A-2	
19. 4/2/21 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hypertensive cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME (Month) (Day) (Year) (Hour) (Approx.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
<p>I certify that I held an inquiry <input type="checkbox"/> inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p> <p>ACTUAL SIGNATURE <i>Ronald N. Kornblum</i> M.D. Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12-11-72</p>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/16/72	
24C. NAME OF CEMETERY or CREMATORY Mt. Calvary		24D. LOCATION (City, town, or county) (State) G.A. County Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1972		25B. NAME OF REGISTRAR Joseph J. Lock	
25C. FUNERAL DIRECTOR Joseph J. Lock		ADDRESS 1304 N. Central Ave	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 11890	
72 11890				STATE OF MARYLAND-DEMT	
BIRTH NO.				DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>ANDERSON, Roy B.</b>				2. DATE AND HOUR OF DEATH <b>12/13/72 - 7 PM</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>BALTIMORE CITY</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>MERCY HOSPITAL 7301 St. PAUL Street. BALTO., MD.</b>				C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>3410 ELLIOTT St. #21224.</b>					
5. SEX <b>MALE</b>	6. RACE <b>CAUC.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>07/2/20</b>	9. AGE (In years lost birthday) <b>52</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DRIVER-Salesman</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>NATIONAL BREW. Co.</b>		11. BIRTHPLACE (State or foreign country) <b>MICHIGAN, DETROIT.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>					
13. FATHER'S NAME <b>ROY B. ANDERSON</b>				14. MOTHER'S MAIDEN NAME <b>ANNIE M. ROTH</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>404-09-6602</b>	
17. INFORMANT <b>VERNETTA M. BONITZ</b>				ADDRESS <b>BOX # 36-A-1, RT. 2 PARKTON, MD</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>571.01</b> <b>Hypovolemic shock &amp; negative coma</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hr.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Acute hemorrhagic anemia</b> <b>Upper GI hemorrhage</b> <b>alcoholic cirrhosis &amp; portal hypertension sm.</b>					
<b>II</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>12</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12-12</b> 19 <b>72</b> to <b>12-13</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>12-13</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>G. VANEGAS, M.D.</b>				23B. DATE SIGNED <b>12-13-72</b>	
23C. PHYSICIAN'S NAME (Type) <b>G. VANEGAS, M.D.</b>				23D. ADDRESS <b>Mercy Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12-16-72</b>		24C. NAME of CEMETERY or CREMATORY <b>CAK LAWN CEM.</b>	
24D. LOCATION (City, town, or county) (State) <b>7225 EASTERN BLVD, BALCO, MD</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 15 1972</b>		25B. NAME OF REGISTRAR <b>Audrey H. ...</b>		25C. FUNERAL DIRECTOR <b>Charles S. Giler</b>	
				ADDRESS <b>9015 CONKLING ST. BALTO., MD.</b>	

15-12

V. G.

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

WOLFFENBUTTEL 1841

DEWICK-24167444 HILLMAN-28815000 WICH-24167444 DEWICK-24167444

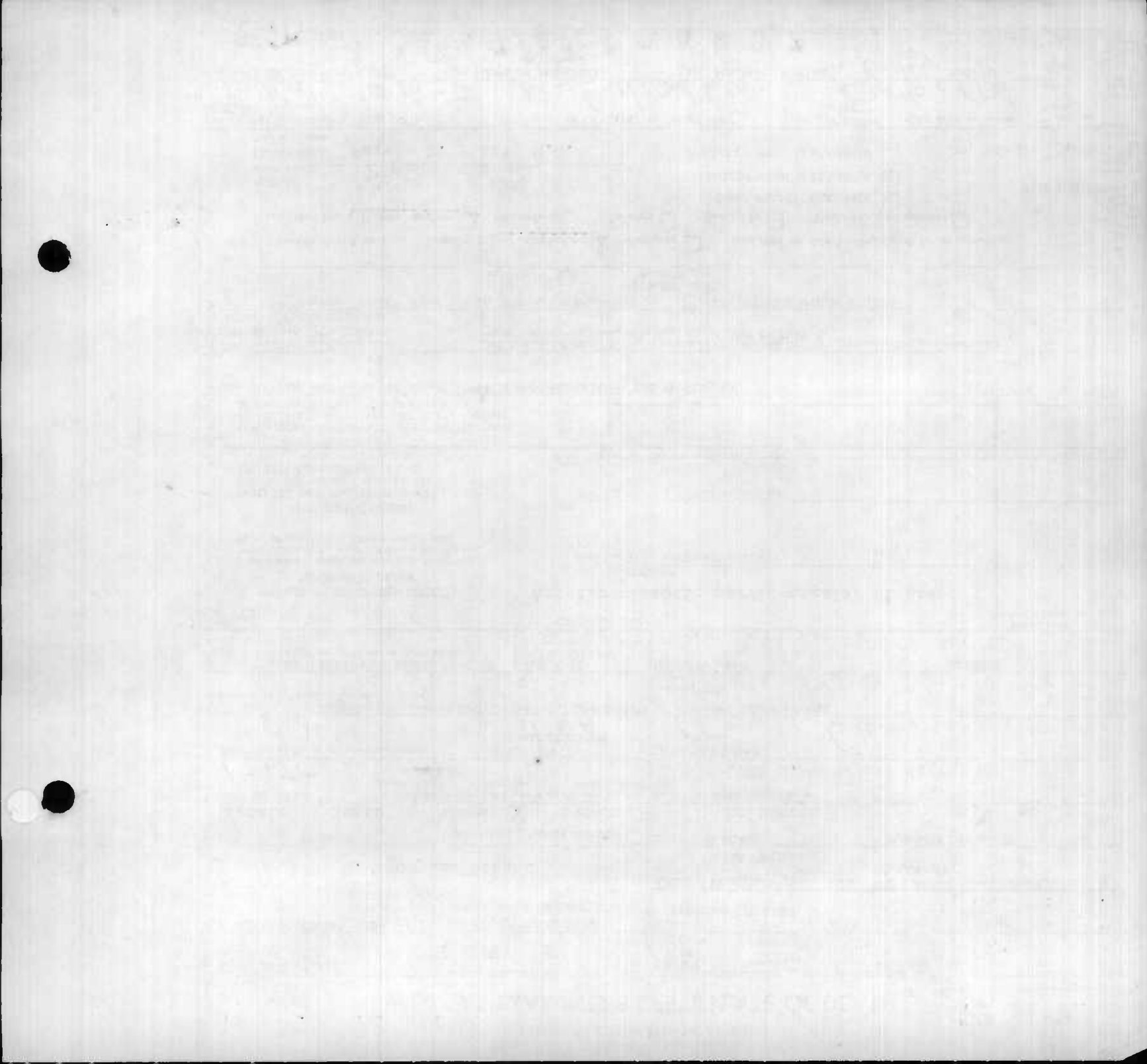
WHITE C. 100 X 21/2/30 25

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>LUCY JOHNSON</b>		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input checked="" type="checkbox"/> <b>December 14, 1972</b>		Hour <b>M.</b>
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>1708 N. Woodyear Street</b>		3. DATE PRONOUNCED DEAD <b>December 14, 1972</b>		Hour <b>9:45 A. M.</b>
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1501</b>				
6. SEX <b>Female</b>	7. RACE <b>Negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>
9. DATE OF BIRTH <b>1-17-92</b>		10. AGE (In years last birthday) <b>80</b>	11. BIRTHPLACE (State or foreign country) <b>Ind.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Manuel Clemons</b>		
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		
15. MOTHER'S MAIDEN NAME <b>Jennie Young</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
17. SOCIAL SECURITY NO. <b>21203-675D</b>		18. INFORMANT <b>MARY Duffin</b>		
19. CAUSE OF DEATH <b>412.41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(A) IMMEDIATE CAUSE</b> DUE TO, OR AS A CONSEQUENCE OF: <b>(B)</b> DUE TO, OR AS A CONSEQUENCE OF: <b>(C)</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>No</b>
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Marvin S. Platt, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Marvin S. Platt, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>December 14, 1972</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>12-18-72</b>	24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cem.</b>	24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 15 1972</b>	25B. NAME OF REGISTRAR <b>Arling W. ...</b>	25C. FUNERAL DIRECTOR <b>V. Bailey</b> ADDRESS <b>1348 Calhoun St.</b>		



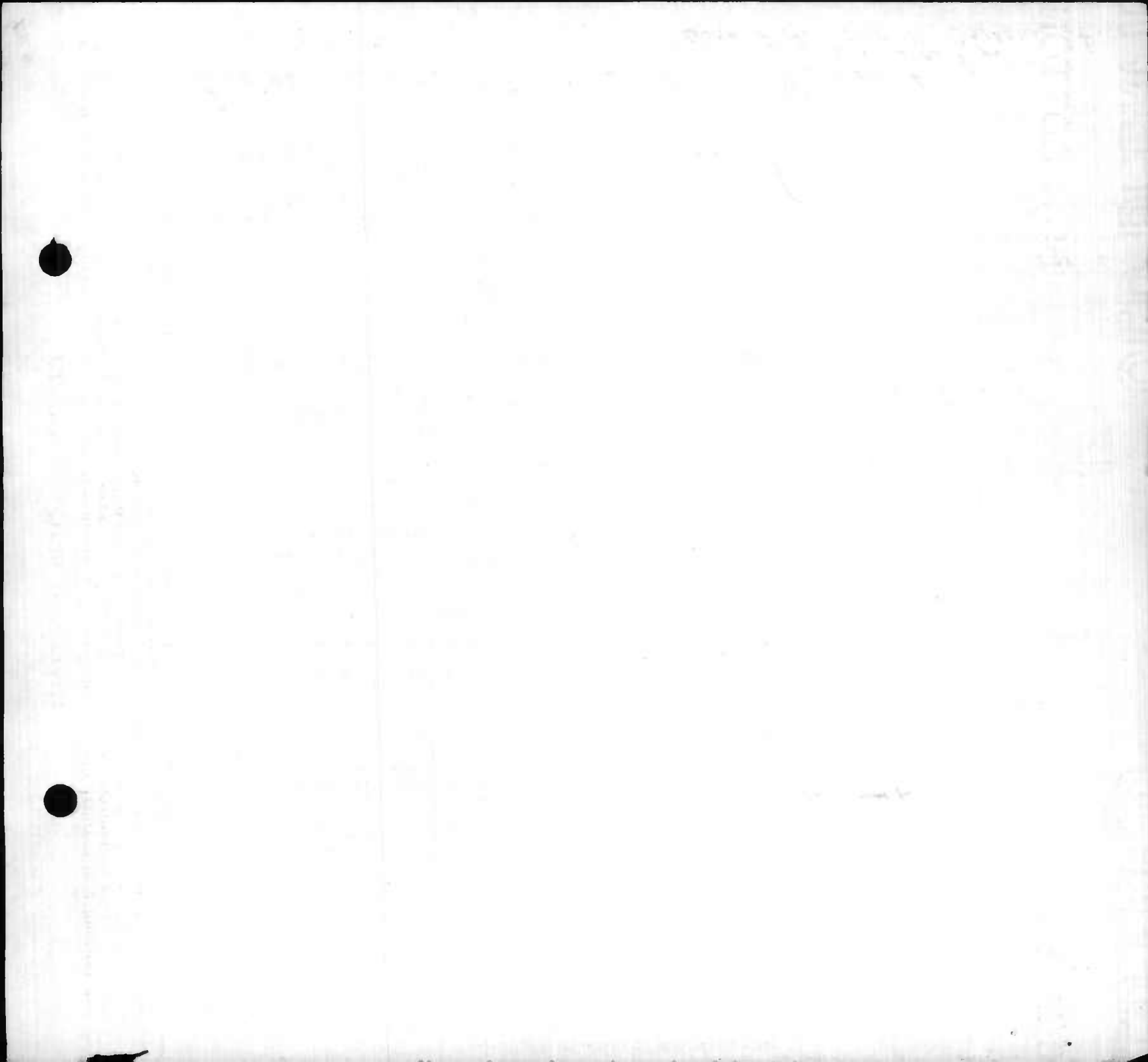


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
72 11892					72 11892				
S-530					72 11892				
BIRTH NO.					REG. NO.				
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH				
Smith, Frank Jr					12-10-72 12:49 A.M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital 2600 Liberty Heights					A. STATE & COUNTY Md 1602				
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION					C. CITY OR TOWN Balto.				
					D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
					E. STREET AND NUMBER 1222 - N. Parrish St. 21217				
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
m		B				5-31-26		46	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					11. BIRTHPLACE (State or foreign country)				
Unemployed					Maryland				
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
					Smith, Sadie				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. (INFORMANT ADDRESS)		
yes					911-20-0433		Smith, Sadie David Park Lake Dr, NF		
18. CAUSE OF DEATH									
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Respiratory Infection metastatic (B) BRONCHOGENIC CA DUE TO, OR AS A CONSEQUENCE OF: (C) _____									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0									
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?			
			While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>						
22. I certify that (X) (this hospital) attended the deceased from 10-19 1972 to 12-10 1972 that (X) (we) last saw the deceased alive on 12-10 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.									
23A. SIGNATURE						23B. DATE SIGNED			
Willie Brooks, M.D.						12-10-72			
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)		
Burial			12-14-72		Mt. Auburn		Westport		
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR			25C. FUNERAL DIRECTOR ADDRESS			
DEC 15 1972			Aldridge, Fred			Y. R. Bailey 1348 N. Calhoun St.			





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-200 72 11893		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 11893 STATE OF MARYLAND-DEATH	
1. NAME OF DECEASED (Type or Print) <u>Lewis, John W.</u>		2. DATE AND HOUR OF DEATH <u>12-10-72</u> <u>19:30</u> A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Lutheran Hospital of Md</u> <u>730 Ashburton St</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1603</u> C. CITY OR TOWN <u>Balto.</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1713 W. Lafayette Ave</u>			
5. SEX <u>M</u>	6. RACE <u>Black</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-17-07</u>	9. AGE (In years last birthday) <u>64</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Longshoreman</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>md.</u>	
13. FATHER'S NAME <u>Wm. Lewis</u>		14. MOTHER'S MAIDEN NAME <u>Ammie Dennis</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. <u>288-18-1063</u>		17. INFORMANT <u>Wm. Ricks</u> ADDRESS <u>1616 Lanvale St.</u>	
18. <u>1621 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cardiac Arrest</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Carcinoma of lung</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>none</u> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>none</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>none</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>none</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>none</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>none</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>none</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12-10-72</u> to <u>12-10-72</u> that (I) (we) last saw the deceased alive on <u>12-10-72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>C.V. Lucas</u> M.D.		23B. DATE SIGNED <u>12-10-72</u>		23C. PHYSICIAN'S NAME (Type) <u>C.V. LUCAS</u> M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/14/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Westport Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 15 1972</u>		25B. NAME OF REGISTRAR <u>Ludwig H. Hooton</u>		25C. FUNERAL DIRECTOR <u>Kelson F.H.</u> ADDRESS <u>1348 N. Calhoun St.</u>	



G-325

72 11894

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 11894

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>(BOOKER T. GOODSON)</b> <b>Booker Goodson</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 12 13 72 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>00 3212 Dupont Avenue</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 13 72 5:40 a. M.	
6. SEX <b>male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>6/22/02</b>		10. AGE (In years last birthday) <b>70</b>	
11. BIRTHPLACE (State or foreign country) <b>Darlington, S.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Tootsie Goodson</b>		14. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2716</b>	
15. STREET AND NUMBER <b>3212 Dupont Avenue</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>		17. SOCIAL SECURITY NO. <b>261-32-0993</b>	
18. INFORMANT <b>Mrs. Effie Goodson</b>		ADDRESS <b>3312 Dupont Avenue</b>	
19. <b>412.41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</b>			
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b>			
22. <b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b>			
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Peter Lipkovic, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Peter Lipkovic, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>12/13/72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/18/72</b>	
24C. NAME of CEMETERY or CREMATORY <b>Mount Auburn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 15 1972</b>		25B. NAME OF REGISTRAR <b>Audrey W. Hinton</b>	
25C. FUNERAL DIRECTOR <b>MORTON &amp; DYETT F.H.</b>		ADDRESS <b>1701 Laurens St.</b>	

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JAMES JOHNSON		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year December 13, 1972		Hour 9:15 P. M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION University Hospital 1-5-73		3. DATE PRONOUNCED DEAD Month Day Year December 13, 1972		Hour 9:15 P. M.
5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2717				
6. SEX Male	7. RACE Negro	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore
9. DATE OF BIRTH 9/15/29		10. AGE (In years last birthday) 43	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country) King William Co., Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		E. STREET AND NUMBER 2733 Clyburn Avenue
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		14B. KIND OF BUSINESS OR INDUSTRY Marketing Serv. Inc.		15. MOTHER'S MAIDEN NAME Daisy Johnson
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes. 1/28/46-12/2/47		17. SOCIAL SECURITY NO. 221-14-9412		18. INFORMANT Mrs. Louise Johnson
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E 812.10 SEPSIS		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Sepsis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) Multiple injuries: crushed pelvis DUE TO, OR AS A CONSEQUENCE OF:		
(C)				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes No.
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Highway		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? #695 North of Rte. #26 5300
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 11-29-72 8:20 A.		22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR? Driver of truck, struck by auto
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED December 14, 1972 ACTUAL SIGNATURE Marvin S. Platt, M.D. EXAMINER'S NAME (Type)				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/18/72	24C. NAME OF CEMETERY or CREMATORY Carver Memorial Park	
24D. LOCATION (City, town, or county) (State) Laurel, Maryland				
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1972		25B. NAME OF REGISTRAR Sidney H. [Signature]		25C. FUNERAL DIRECTOR MORTON G. DYETT F.H.
				ADDRESS 1701 Laurens St.





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 11896

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Robert L. Lewis, Jr.		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month 12	Day 13	Year 72	Hour
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 42 Sinai Hospital		3. DATE PRONOUNCED DEAD		Month 12	Day 13	Year 72	Hour 12:10 p.m.
6. SEX male		7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 10/11/43		10. AGE (in years last birthday) 29		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		E. STREET AND NUMBER 4546 Pimlico Road	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Robert L. Lewis, Sr.		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian		15. MOTHER'S MAIDEN NAME Dorothy Harper	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No.		17. SOCIAL SECURITY NO. 212-42-9377		18. INFORMANT Mrs. Dorothy Lewis		ADDRESS 5101 Belleville Ave.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH Gunshot wounds of chest (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION 1		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) SCHOOL		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Poly Western High School 4700 Falls Road			
22D. TIME OF INJURY (APPROX.) 12 13 72 11:30 a.m.		22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR? Subject was shot.		2775	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12/13/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/18/72		24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1972		25B. NAME OF REGISTRAR Siding		25C. FUNERAL DIRECTOR MORTON & DYETT F.H.		ADDRESS 1701 Laurens St.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
B-653		72 11897		72 11897	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
SADIE BRANTLEY (BRANTLY)		12/14/72 3:10 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
THE JOHNS HOPKINS HOSPITAL		MD. A.A.			
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
FEMALE		NEGRO		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday)	
Housewife				68	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		11. BIRTHPLACE (State or foreign country)	
Unk.		Vonnice Jackson		Georgia	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No.				Mr. Norman Brantley Box 194, Pasadena, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		2 who	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		10 months	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) ASCVD		25 yrs.	
II		Anemia			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
		No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/30 1972 to 12/14 1972, that (I) (we) last saw the deceased alive on 12/14 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE		23B. DATE SIGNED	
CRAIG R. SMITH M.D.		12/14/72			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
CRAIG R. SMITH M.D.		601 N. BROADWAY, BALTIMORE, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		12/18/72		Mount Calvary Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
DEC 15 1972		MORTON & DYETT F.H.		1701 Laurens Street	

OSWIG & S W/TH

W.D.

FOR IN GRADUATE, BUT NOT IN

THURSDAY 1944

W.D.

X

10/14/44

○

○○

10/14/44

○

10/14/44

THURSDAY

10/24

THURSDAY 1944

10/24

10/24/44

THURSDAY

10/24

10/14/44 3:10 PM

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 11898

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>WALTER JONES SR.</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>South Baltimore General Hosp. (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>12 11 1972 10:20a.m.</b>	
6. SEX <b>male</b>		7. RACE <b>negro</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>11-29-11</b>		10. AGE (In years last birthday) <b>61</b>	
11. BIRTHPLACE (State or foreign country) <b>MONROE, GEORGIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>REV. CLARENCE JONES</b>		14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2552</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY <b>HOUSING AUTHORITY</b>	
15. MOTHER'S MAIDEN NAME <b>MARY JONES</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>	
17. SOCIAL SECURITY NO. <b>254-05-2403</b>		18. INFORMANT ADDRESS <b>MRS. MABEL JONES 733 ROUNDVIEW ROAD</b>	
19. CAUSE OF DEATH <b>412.21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Hypertensive cardiovascular disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____	
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____	
21. AUTOPSY? (Yes or No) <b>NO</b>		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>12-11-72</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12-15-72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>ARBUTUS MEMORIAL PARK</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 15 1972</b>		25B. NAME OF REGISTRAR <b>Lidney Johnston</b>	
25C. FUNERAL DIRECTOR <b>MORTON &amp; DYETT F. H.</b>		25D. ADDRESS <b>1701 LAURENS ST.</b>	

OFFICE

197

1-1-71

1-1-71

1-1-71

1-1-71

1-1-71

1-1-71

OFFICE

197

1-1-71

1-1-71

1-1-71

1-1-71

1-1-71

1-1-71

OFFICE

197

1-1-71

1-1-71

1-1-71

1-1-71

1-1-71

1-1-71

OFFICE

197

1-1-71

1-1-71

1-1-71

1-1-71

1-1-71

1-1-71

OFFICE

197

1-1-71

1-1-71

1-1-71

1-1-71

1-1-71

1-1-71

OFFICE

197

1-1-71

1-1-71

1-1-71

1-1-71

1-1-71

1-1-71

OFFICE

197

1-1-71

1-1-71

1-1-71

1-1-71

1-1-71

1-1-71

OFFICE

197

1-1-71

1-1-71

1-1-71

1-1-71

1-1-71

1-1-71

OFFICE

197

1-1-71

1-1-71

1-1-71

1-1-71

1-1-71

1-1-71

OFFICE

197

1-1-71

1-1-71

1-1-71

1-1-71

1-1-71

1-1-71

OFFICE

197

1-1-71

1-1-71

1-1-71

1-1-71

1-1-71

1-1-71

OFFICE

197

1-1-71

1-1-71

1-1-71

1-1-71

1-1-71

1-1-71

OFFICE

197

1-1-71

1-1-71

1-1-71

1-1-71

1-1-71

1-1-71

OFFICE

197

1-1-71

1-1-71

1-1-71

1-1-71

1-1-71

1-1-71

OFFICE

197

1-1-71

1-1-71

1-1-71

1-1-71

1-1-71

1-1-71

OFFICE

197

1-1-71

1-1-71

1-1-71

1-1-71

1-1-71

1-1-71

OFFICE

197

1-1-71

1-1-71

1-1-71

1-1-71

1-1-71

1-1-71

OFFICE

197

1-1-71

1-1-71

1-1-71

1-1-71

1-1-71

1-1-71

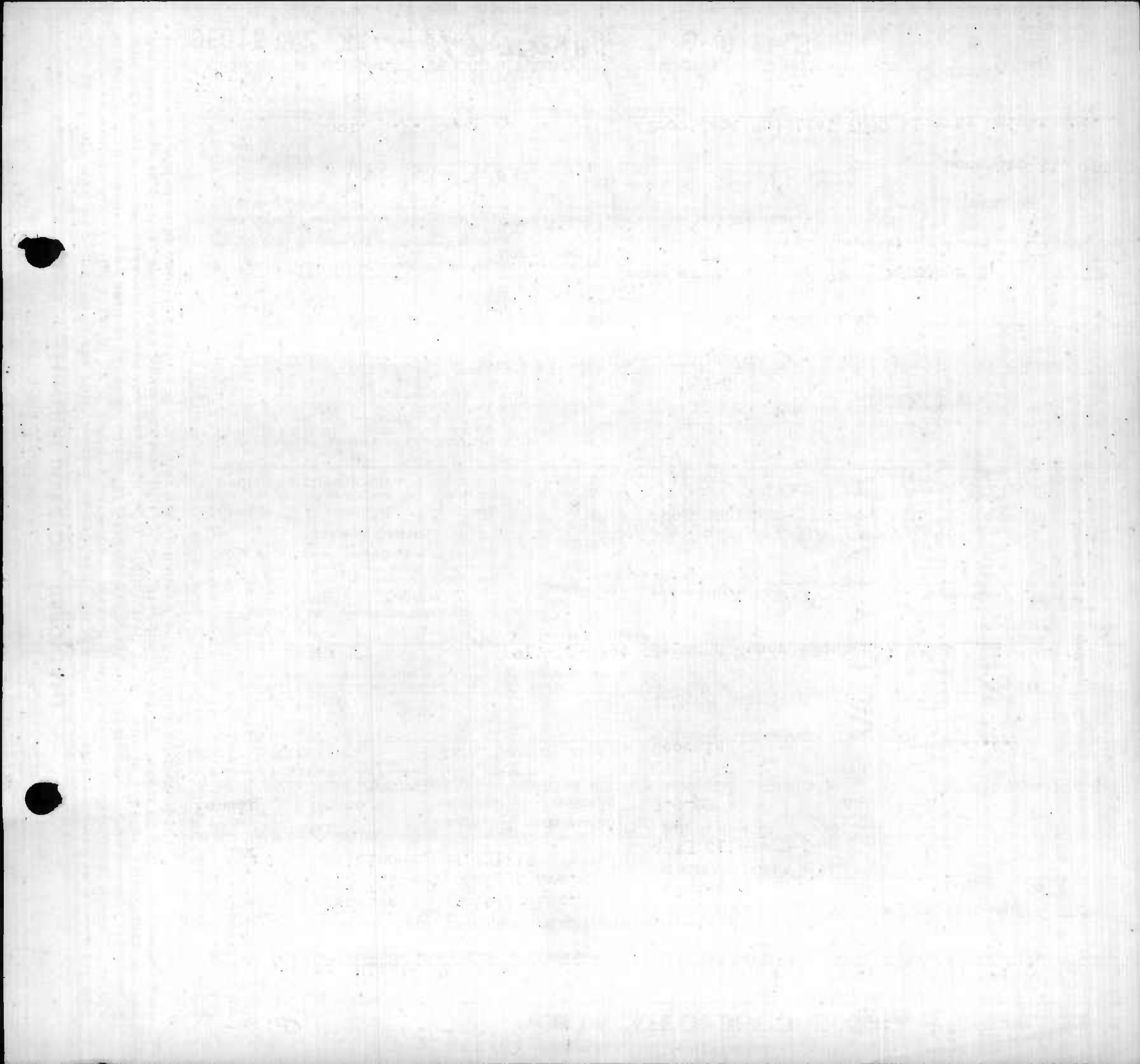


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-260		72 11899		BALTIMORE CITY HEALTH DEPARTMENT		72 11899	
CERTIFICATE OF DEATH				STATE OF MARYLAND			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
		Cesar, Minnie Bowden		December 10, 1972		4:25 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
39		Provident Hospital, Inc. 2600 Liberty Height Ave. Baltimore, Md. 21215		Maryland		2733	
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				4815 Gilray Drive			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	9. AGE (In years last birthday)	10. UNDER 1 Yr. Months Days	
Female	Negro	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		7-9-08	64		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
social worker		Loch Raven Hosp.		Georgia		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Milas Bowden				Clara Baylor			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
Yes		WW II		461-26-5370		Raymond Cesar (Husband) SAME	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				HYPERTROPHY MYOCARDIUM			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) CONGESTIVE HEART FAILURE			
				(C) EARLY HYPOSTATIC PNEUMONIA			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2				YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from December 9, 1972 to December 10, 1972, that (I) (we) last saw the deceased alive on December 10, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Loot, M.D.				December 11, 1972			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		23E. FUNERAL DIRECTOR		ADDRESS	
		Provident Hospital 2600 Liberty Height Ave.		Herbert E. Nutter		3035 W. North Ave	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		12/15/72		& Family Lot		Brunswick, Georgia	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
DEC 15 1972		Andrew Johnson		Herbert E. Nutter		3035 W. North Ave	





72 11800

STATE OF MARYLAND-DEMD  
BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 11800

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Frances Armeta Martin</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month <b>12</b> Day <b>12</b> Year <b>72</b> Hour <b></b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 3125 Belvedere Avenue</b>		3. DATE PRONOUNCED DEAD Month <b>12</b> Day <b>12</b> Year <b>72</b> Hour <b>5:45 p.</b> M.	
6. SEX <b>female</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>1604</b>	
9. DATE OF BIRTH <b>6/5/13</b>		10. AGE (In years lost birthday) <b>59</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>clerk</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Dry Cleaning</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		17. SOCIAL SECURITY NO. <b>215 22 3508</b>	
13. FATHER'S NAME <b>Winfrey H. White</b>		15. MOTHER'S MAIDEN NAME <b>Estella Lee</b>	
18. INFORMANT <b>Charles V. Martin</b>		ADDRESS <b>3507 Lynchester Rd</b>	
19. <b>E966X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH <b>Stabwounds of chest</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>STORE</b>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>8 3125 Belvedere Ave. (Dry Cleaner)</b>		22D. TIME OF INJURY (APPROX.) Month <b>12</b> Day <b>12</b> Year <b>72</b> Hour <b>unk.</b>	
22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Subject was stabbed by unknown assailant</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Peter Lipkovic, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>12/13/72</b> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/16/72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>St. Lukes</b>		24D. LOCATION (City, town, or county) (State) <b>Reistersdown, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 15 1972</b>		25B. NAME OF REGISTRAR <b>Sidney Johnson</b>	
25C. FUNERAL DIRECTOR <b>Gerder E6</b>		ADDRESS <b>Nutter 3035 W. North Ave</b>	

N875-1

1974-1975

BOOK 10

1974-1975

1974-1975

1974-1975

1974-1975

1974-1975

1974-1975

1974-1975

1974-1975

1974-1975

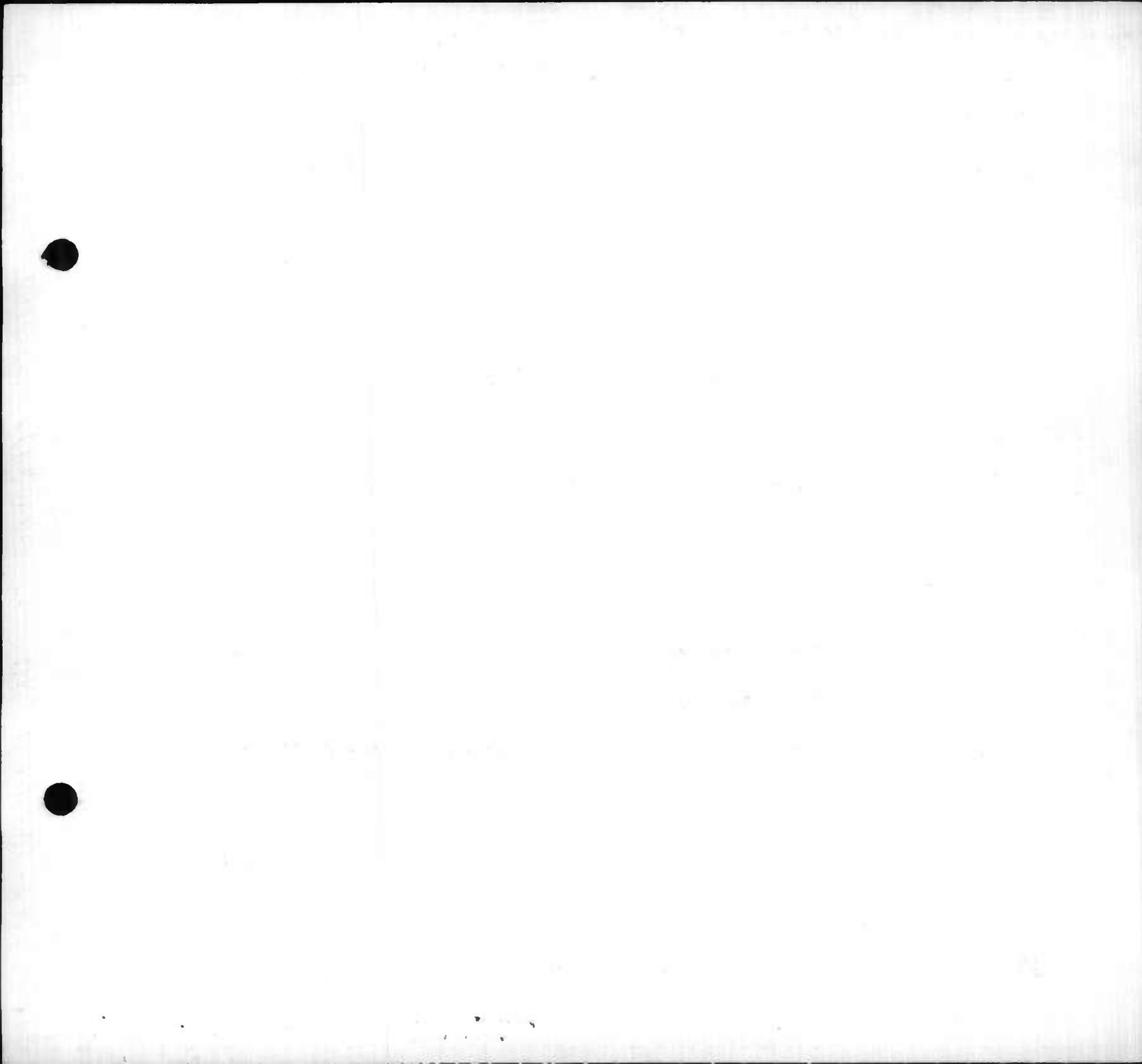
1974-1975

CERTIFICATION APPLIED FOR ON APPROVAL OF DR. LIPKOVIC (MEDICAL EXAMINER)

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

N-400		72 11802		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 11801	
BIRTH NO.		CERTIFICATE OF DEATH				STATE OF MARYLAND - DEATH	
1. NAME OF DECEASED (Type or Print)		NEAL, WILLIAM WILLIE		2. DATE AND HOUR OF DEATH		12/12/72 12 57 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
GOOD SAMARITAN HOSPITAL 45				MARYLAND BALTO. 1802			
5. SEX M				6. RACE BLACK		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
LONG SHORE MAN				WATERFRONT		BALTIMORE	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
LEE GRANT NEAL				NATTIE CRAIG			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				217 01 2522		HELEN NEAL 117 N. CAREY ST.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE			
ANTECEDENT CAUSES				DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				NEEDLE BIOPSY OF LUNG 45 min			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) MILIARY PULMONARY NODULES 6 months			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CACHEXIA + CHF 6 months			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
12/12/72		PULMONARY NODULES		NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12/15/72 19 to 12/12/72 19 that (I) (we) last saw the deceased alive on 12/12/72 19 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
David Harrison M				12/12/72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
DAVID HARRISON MD				GOOD SAMARITAN HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		12/16/72		Mt. Auburn		BALTIMORE MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
DEC 15 1972		Dorothy M. [unclear]		HERBERT E. NOTTER		3035 W North Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

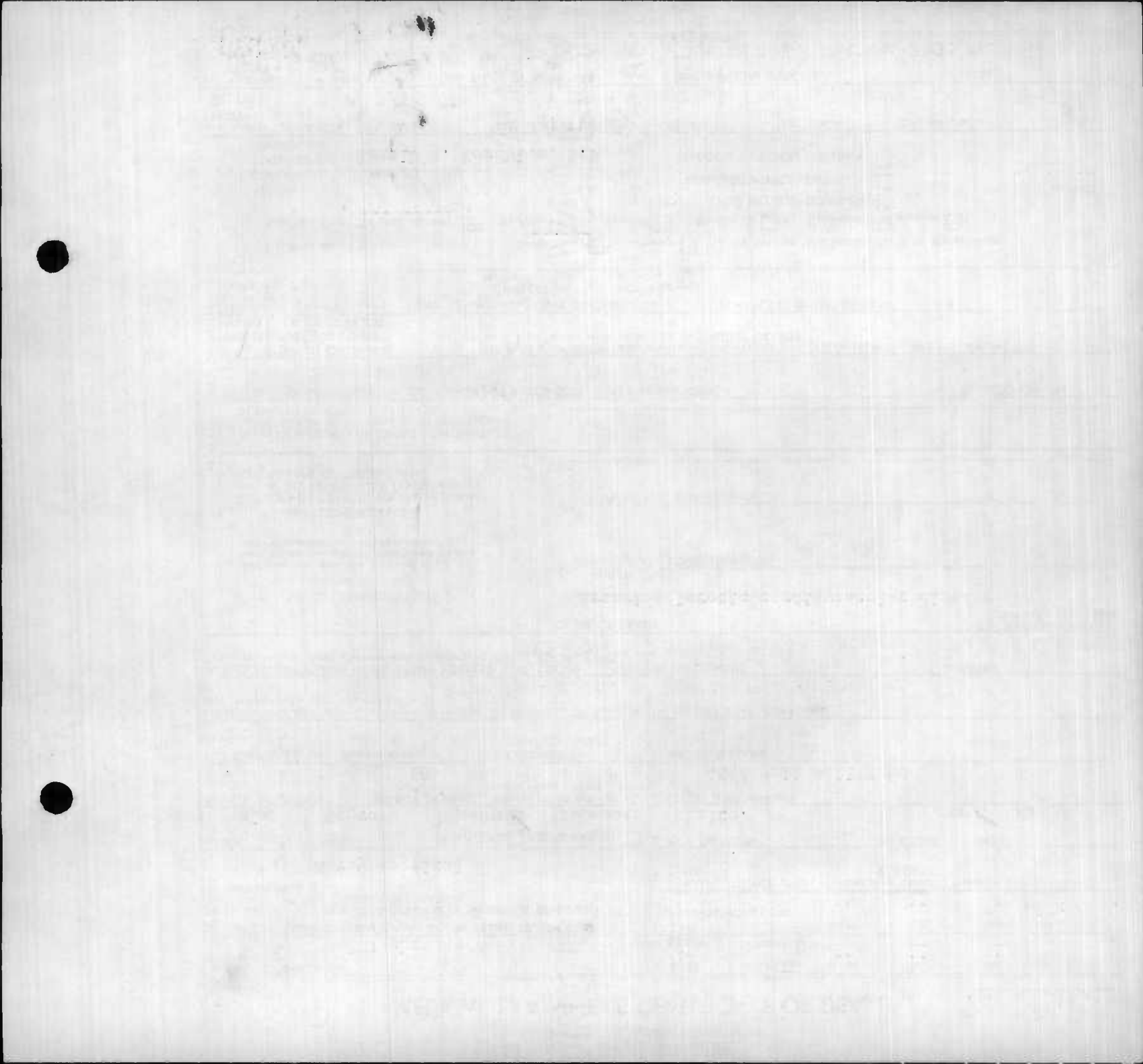
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 72 11902 STATE OF MARYLAND-DEATH	
BIRTH NO. <u>R-152</u>		72 11902		1. NAME OF DECEASED (Type or Print) <u>Robinson, John H.</u>		2. DATE AND HOUR OF DEATH <u>DEC 8 1972</u> <u>2<sup>30</sup> A M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>90 Pleasant Manor Nursing Home</u> <u>4615 Park Heights Avenue</u> <u>Baltimore, Maryland 21215</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2562</u>			
				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>2807 Round Road</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>04/07/06</u>	9. AGE (in years last birthday) <u>66</u>	If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Guidance counselor Douglass High</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>David T. Robinson</u>			
14. MOTHER'S MAIDEN NAME <u>Rosabelle Easton</u>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>104-03-9266</u>				17. INFORMANT <u>Lillie Logan</u> ADDRESS <u>2807 Round Road</u>			
18. <u>34721</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>None</u>				(A) IMMEDIATE CAUSE <u>Cerebral Hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Parkinson Disease</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Arteriosclerotic Heart Disease</u> (C) <u>None</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>1 year</u> <u>1 year</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>Oct 23</u> <u>1972</u> to <u>Dec 8</u> <u>1972</u> that (I) (we) last saw the deceased alive on <u>Dec 8</u> <u>1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Manuel Levin MD</u>				23B. DATE SIGNED <u>12/8/72</u>		23C. PHYSICIAN'S NAME (Type) <u>Manuel Levin</u>	
23D. ADDRESS <u>6101 Park Heights Avenue</u>							
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/13/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Arbutus Memorial Park</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Co., Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 15 1972</u>		25B. NAME OF REGISTRAR <u>Sidney</u>		25C. FUNERAL DIRECTOR <u>Herbert E. Nutter</u>		ADDRESS <u>3035 W. North Ave</u>	





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 72 11903

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Paul Jackson		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 12 11 72 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 Mercy Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 11 72 12:30 P.M.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2716	
6. SEX male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 4/16/12		10. AGE (in years last birthday) 60	11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		14B. KIND OF BUSINESS OR INDUSTRY Baer Paper Co.		13. FATHER'S NAME Eddie Jackson	
15. MOTHER'S MAIDEN NAME Hattie Henderson		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, give war or dates of service) NO		17. SOCIAL SECURITY NO. 213 07 6452	
18. INFORMANT Alice E. Jackson		ADDRESS 4646 Pall Mall Road		21. AUTOPSY? (Yes or No) no	
19. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <i>Ronald N. Kornblum</i> M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. DATE SIGNED 12/12/72					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/16 72		24C. NAME of CEMETERY or CREMATORY Rose Lawn Memorial Garden Hanover Co., Virginia	
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1972		25B. NAME OF REGISTRAR <i>Lidney</i>		25C. FUNERAL DIRECTOR Herbert E. Nutter 3035 W. North Ave	



CERTIFICATION APPROVED BY

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CHIEF OR ASST. MEDICAL EXAMINER

MEDICAL CERTIFICATION

<p><b>E-140</b>      72-11904      <b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p><b>CERTIFICATE OF DEATH</b></p>		<p>REG. NO. <b>72 11904</b></p>	
<p>BIRTH NO.</p>		<p>STATE OF <b>MARYLAND</b></p>	
<p>1. NAME OF DECEASED (Type or Print) <b>WALTER L. EPPEL JR.</b></p>		<p>2. DATE AND HOUR OF DEATH <b>10 DEC 1972 11 30 A.M.</b></p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>HARFORD</b></p>	
<p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>38 UNIVERSITY HOSPITAL BALTIMORE, MD 21201</b></p>		<p>C. CITY OR TOWN <b>HARFORD</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	
<p>E. STREET AND NUMBER <b>709 St. James Terr.</b></p>			
<p>5. SEX <b>male</b></p>	<p>6. RACE <b>white</b></p>	<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <b>2 Aug 1923</b></p>
<p>9. AGE (In years last birthday) <b>49</b></p>		<p>10. UNDER 1 Yr. Months: Days: Hours: Min.</p>	<p>11. UNDER 24 Hrs. Hours: Min.</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electronic Tech.</b></p>		<p>10B. KIND OF BUSINESS OR INDUSTRY <b>Weather Bureau Govt.</b></p>	
<p>11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b></p>		<p>12. CITIZEN OF WHAT COUNTRY? <b>USA</b></p>	
<p>13. FATHER'S NAME <b>Walter Eppel SR.</b></p>		<p>14. MOTHER'S MAIDEN NAME <b>Marian Murphy</b></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give War or dates of service) <b>Yes 1940-1955</b></p>		<p>16. SOCIAL SECURITY NO. <b>202-22-1549</b></p>	
<p>17. INFORMANT <b>Havre de Grace, Md. 21078</b></p>		<p>ADDRESS <b>Regina G. Eppel, 709 St. James Terrace</b></p>	
<p>18. CAUSE OF DEATH <b>E8801X</b></p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>	
<p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p>		<p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Left Subdural Hematoma</b></p>	
<p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>(B) DUE TO, OR AS A CONSEQUENCE OF: <b>cardiac arrest x2</b></p>	
<p>(C) _____</p>			
<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>cardiac arrest x2</b></p>			
<p>19A. DATE OF OPERATION <b>3 Dec 72</b></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Subdural hematoma</b></p>	
<p>20A. AUTOPSY? (Yes or No) <b>YES</b></p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>None</b></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>None</b></p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Havre de Grace, Md</b></p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>Dec 2 1972 PM</b></p>	
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR? <b>fell down steps</b></p>	
<p>22. I certify that (1) (this hospital) attended the deceased from <b>3 Dec 72</b> to <b>10 Dec 72</b> that (2) (we) last saw the deceased alive on <b>10 Dec 72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <b>Wm Gregory Bruce</b></p>		<p>23B. DATE SIGNED <b>10 Dec 72</b></p>	
<p>23C. PHYSICIAN'S NAME (Type) <b>Wm Gregory Bruce</b></p>		<p>23D. ADDRESS <b>Harford Memorial Gardens</b></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b></p>		<p>24B. DATE <b>12/13/1972</b></p>	
<p>24C. NAME OF CEMETERY or CREMATORY <b>Harford Memorial Gardens</b></p>		<p>24D. LOCATION (City, town, or county) (State) <b>Aberdeen, Harford, Maryland</b></p>	
<p>25A. DATE REC'D BY HEALTH DEPT. <b>DEC 15 1972</b></p>		<p>25B. NAME OF REGISTRAR <b>Dr. [Signature]</b></p>	
<p>25C. FUNERAL DIRECTOR <b>Tarring Funeral Home, Aberdeen, Md. 21001</b></p>		<p>25D. ADDRESS <b>1001 [Address]</b></p>	

UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT

SECTION 10

ISS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 80811-21

BIRTH NO. <u>72-11905</u>		2. DATE AND HOUR OF DEATH <u>12/11/72 5:10 PM</u>	
1. NAME OF DECEASED (Type or Print) <u>Davis, Bertha</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2006</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <u>Provident Hospital, Inc.</u> <u>2600 Liberty Height Ave.</u> <u>Baltimore, Md. 21215</u>		C. CITY OR TOWN <u>Baltimore,</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>Female</u> 6. RACE <u>Negro</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/10/80</u> 9. AGE (In years last birthday) <u>82</u> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retire</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES Gaither</u>		14. MOTHER'S MAIDEN NAME <u>FLATEWILL A ROLLINS</u>	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218-12-8923</u>	
17. INFORMANT <u>NONE Alice Palmer</u>		ADDRESS <u>3148 eeds ST.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Septicemia</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 mps</u>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Multiple Decubitus Ulcers</u>		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>General mms</u>	
(C) <u>Dehydration &amp; Malnutrition</u>		<u>Unknown</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>GI Bleeding Etio. Undetermined</u>			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>11/19</u> 19 <u>72</u> to <u>12/11</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>12/11</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>M. P. COMBATIR</u>		23B. DATE SIGNED <u>12/11/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>M. P. COMBATIR</u>		23D. ADDRESS <u>Provident Hospital 2600 Liberty Height Ave.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-16-72</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>Western Star</u>		24D. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
25A. DATE RECD BY HEALTH DEPT. <u>DEC 18 1972</u>		25B. NAME OF REGISTRAR <u>Edw. J. Edwards</u>	
25C. FUNERAL DIRECTOR <u>Wesley Chavis</u>		ADDRESS <u>1927 Edwards</u>	

7/31/72  
318 Leeds St.  
D



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 72 11906		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 11906	
STATE OF MARYLAND - DEPT		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Robert Miller		2. DATE AND HOUR OF DEATH 12/12/72		4:20 a.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Johns Hopkins Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2407 Herkimer Street			
5. SEX Male	6. RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/3/22	9. AGE (in years last birthday) 50	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Heater		10B. KIND OF BUSINESS OR INDUSTRY American Standard Co.		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Edwin Miller		14. MOTHER'S MAIDEN NAME Florence Ebling	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W W II		16. SOCIAL SECURITY NO. 169-18-5729		17. INFORMANT Mrs. Sophia Miller, 2407 Herkimer Street 21230	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Disseminated Carcinomatosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/11/72 to 12/12/72, that (I) (we) last saw the deceased alive on 12/12/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Bruce Stechmiller M.D.		23B. DATE SIGNED 12/12/72		23C. PHYSICIAN'S NAME (Type) Bruce Stechmiller, M.D.	
23D. ADDRESS The Johns Hopkins Hospital		23E. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		23F. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-15-1972		24C. NAME OF CEMETERY or CREMATORY Meadowridge Cemetery	
24D. LOCATION (City, town, or county) (State) Wash. Blvd. Howard Co., Md.		24E. NAME OF REGISTRAR Andrew Johnston		24F. DATE REC'D BY HEALTH DEPT. DEC 18 1972	



100

11

12-1-1913

100

11

C

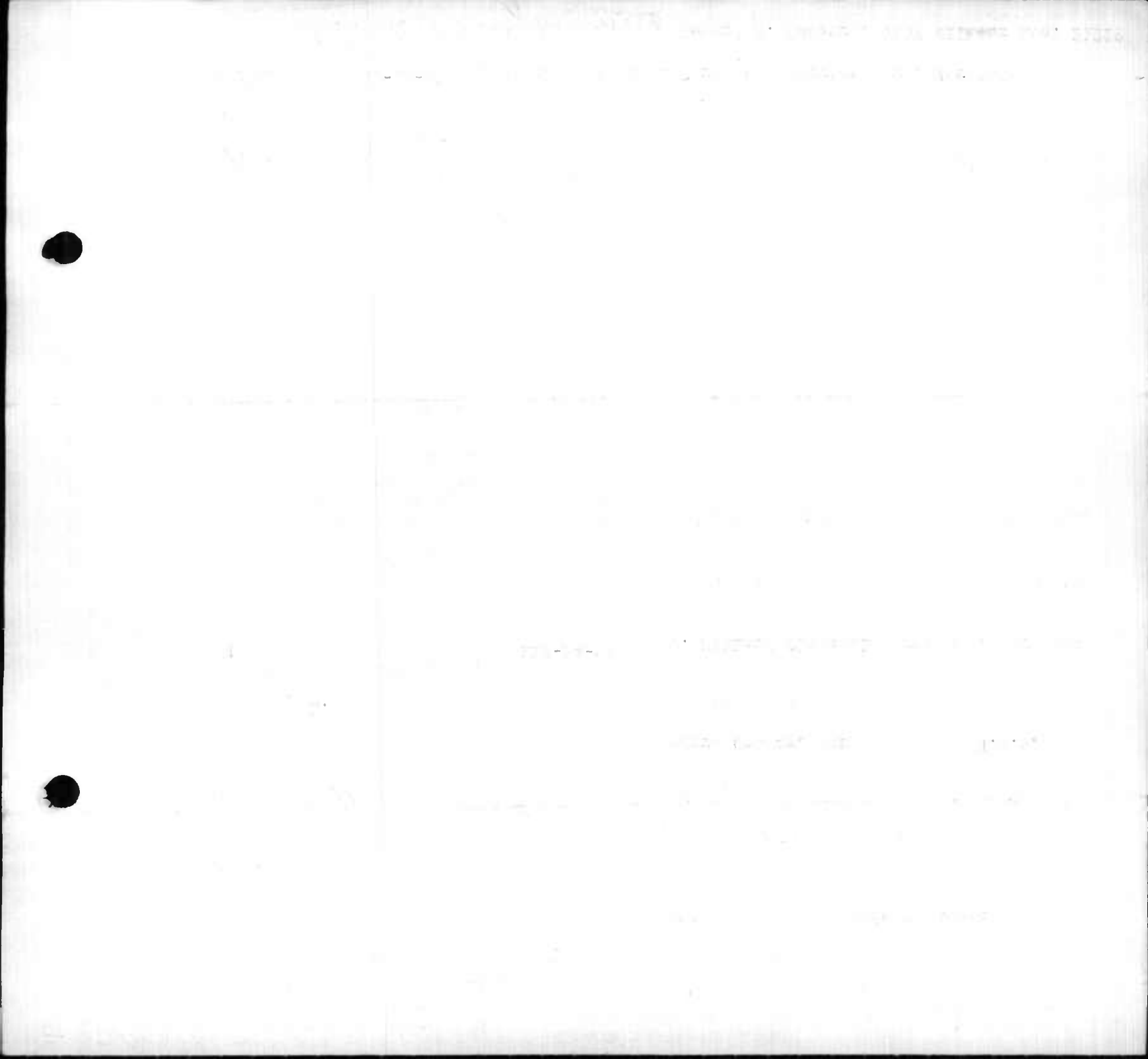
12-1-1913

100

# FUNERAL DIRECTOR: IMPORTANT

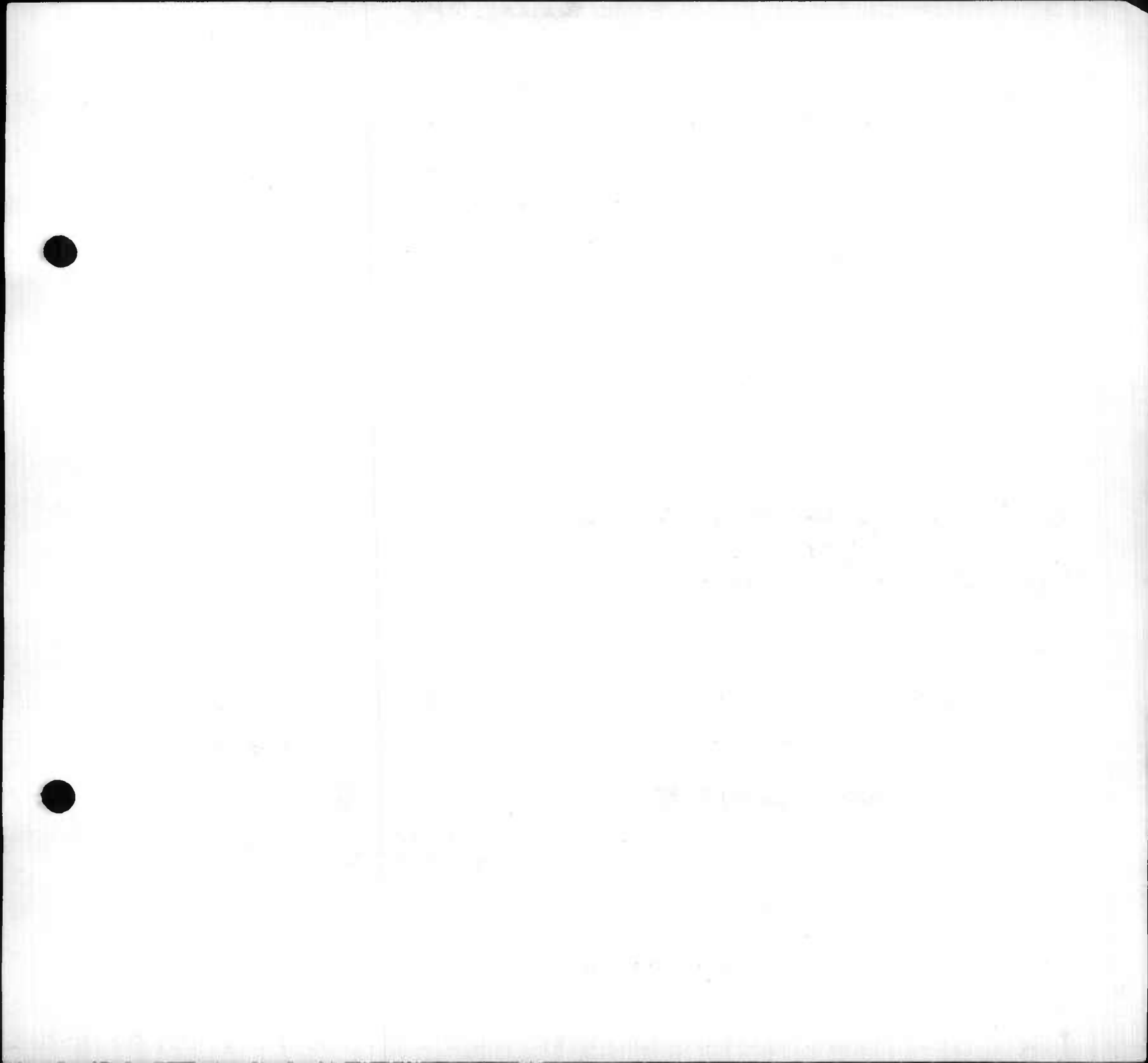
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 72 11907		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		X REG. NO. 72 11907	
1. NAME OF DECEASED (Type or Print) <u>Barbara Ellen Phypers</u>				2. DATE AND HOUR OF DEATH <u>12/12/72 - 15:55 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>U. of Md Hospital 38</u>				A. STATE <u>MD</u>		B. COUNTY <u>Prince George 6600</u>	
5. SEX <u>F</u>				6. RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>8/1/41</u>				9. AGE (In years last birthday) <u>31</u>		10. If Under 1 Yr. Months Days	
11. BIRTHPLACE (State or foreign country) <u>Howard County, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>DAVID L. POOTZ</u>				14. MOTHER'S MAIDEN NAME <u>CORA DASHER</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>227-54-9166</u>		17. INFORMANT ADDRESS <u>Mr. Millard Gladwell, Broadway, Virginia</u>	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE <u>PNEUMONIA</u>			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				(B) <u>ACUTE MONO-MYELOCYTIC LEUKEMIA</u>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost.				DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____				_____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				_____			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		_____	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?		_____	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		_____		_____	
22. I certify that (I) (this hospital) attended the deceased from <u>11/12</u> 19 <u>72</u> to <u>12/12</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on _____ 19_____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Andrew Metzger MD</u>				23B. DATE SIGNED <u>12/12/72</u>		23C. PHYSICIAN'S NAME (Type) <u>ANDREW METZGER MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>12-14-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Resthaven Memorial Gardens</u>	
24D. LOCATION (City, town, or county) <u>Harrisonburg, Virginia</u>				24E. DATE REC'D BY HEALTH DEPT. <u>DEC 18 1972</u>		24F. NAME OF REGISTRAR <u>Sidney Hubbard</u>	
24G. FUNERAL DIRECTOR <u>Howard H. Hubbard</u>				24H. ADDRESS <u>4107 Wilkens Ave. 21229</u>		_____	



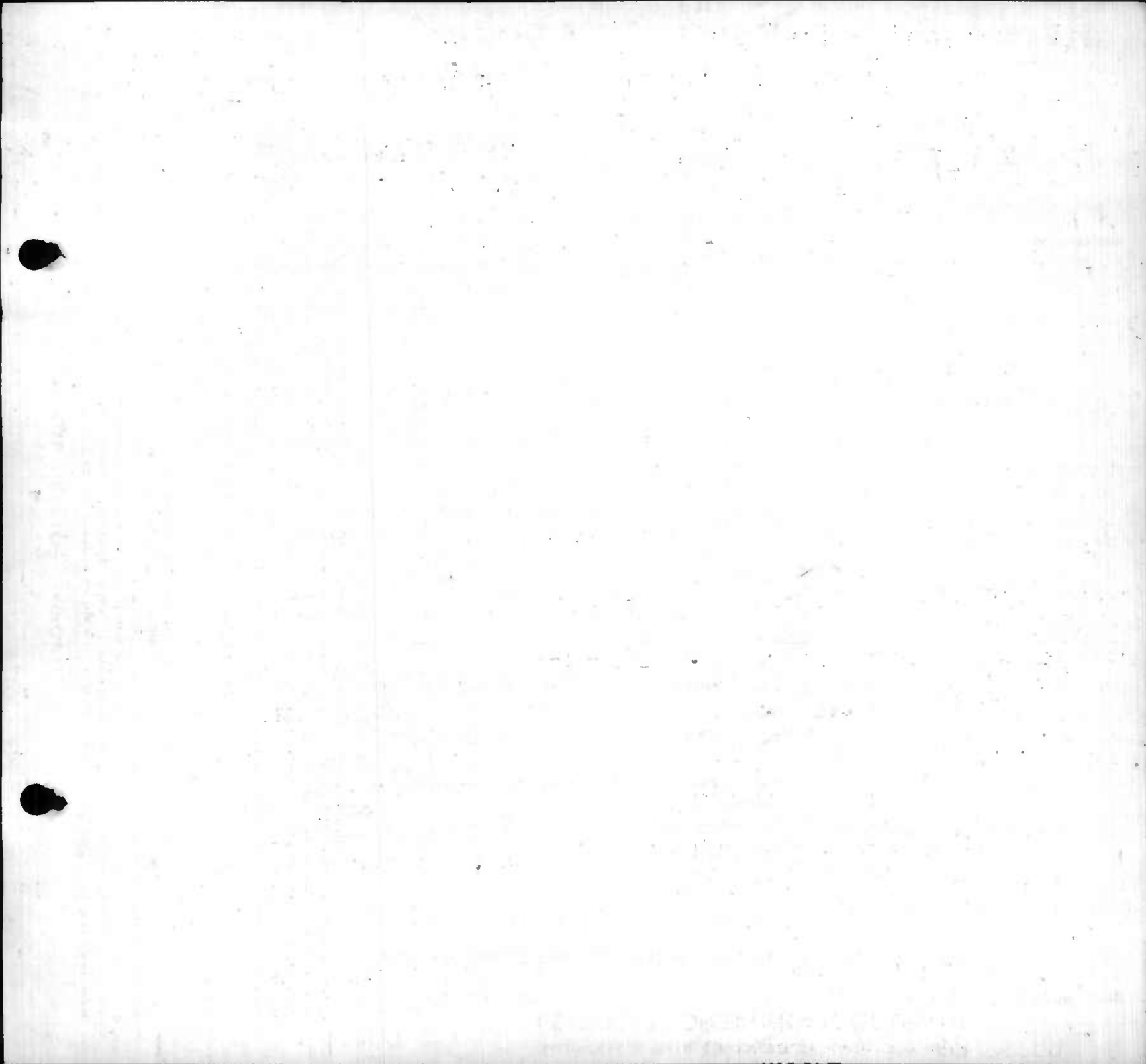
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-6301		BALTIMORE CITY HEALTH DEPARTMENT		72 11908	
72 11908		CERTIFICATE OF DEATH		REG. NO. 72 11908	
BIRTH NO. 01-01-95		1. NAME OF DECEASED (Type or Print) WARD, Willie L. OR William L. WARD		2. DATE AND HOUR OF DEATH 12-9-72 6:25 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY Baito. Md. 2002		C. CITY OR TOWN Baito. Md.	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Bon Secour Hospital 2025 W. FAYETTE ST. Baito. Md. 21223		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 2558 W. FAIRMOUNT AVE.	
5. SEX M	6. RACE B	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 01-01-04	9. AGE (In years last birthday) 68	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Georgia	
13. FATHER'S NAME William WARD		14. MOTHER'S MAIDEN NAME SARAH Watts		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-09-1461		17. INFORMANT Marie Ward 2558 W. Fairmount Ave.	
18. 43391		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Thrombosis of right middle cerebral artery (B) Cerebral arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF: (C)		days years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-20 1972 to 12-9 1972 that (I) (we) last saw the deceased alive on 12-9 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE B. Aranas, M.D.		23B. DATE SIGNED 12-9-72		23C. PHYSICIAN'S NAME (Type) BONIFACIO B. ARANAS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/14/72		24C. NAME OF CEMETERY or CREMATORY Mt Calvary	
24D. LOCATION (City, town, or county) (State) Brooklyn Md		25A. DATE REC'D BY HEALTH DEPT. DEC 18 1972		25B. NAME OF REGISTRAR Sidney [unclear]	
25C. FUNERAL DIRECTOR Charles & Rice		25D. ADDRESS 1300 Eutaw Rd.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

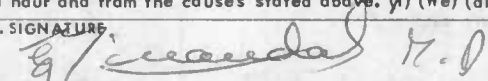
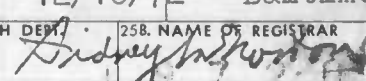
W-6301		72 11909		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 11909	
BIRTH NO. 72 11909				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Woodie Ward				2. DATE AND HOUR OF DEATH December 8, 1972			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 46 Lutheran Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1607 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1510 Poplar Grove Street			
5. SEX Male	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/12/1911	9. AGE (in years last birthday) 61	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffer			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME William Ward			14. MOTHER'S MAIDEN NAME Sarah Watts				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 258-18-8730		17. INFORMANT ADDRESS Annie M. Ward 1510 Poplar Grove St.		
18. I 162.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) Congestive Heart Failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Carcinoma of the lungs 8 years II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
22. I certify that (I) (this hospital) attended the deceased from 5-10-1972 to 12-8-1972, that (I) (we) last saw the deceased alive on 3-5-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE William Watts				23B. DATE SIGNED 12-11-72		23C. PHYSICIAN'S NAME (Type) William A. Watts	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 12/12/72		24C. NAME OF CEMETERY OR CREMATORY Maryland Nat'l Mem. Park	
25A. DATE REC'D BY HEALTH DEPT. DEC 18 1972				25B. NAME OF REGISTRAR Sydney H. Hinton		25C. FUNERAL DIRECTOR Charles A. Rice	
				25D. LOCATION (City, town, or county) Laurel, Maryland		25E. ADDRESS 1300 N. Eutaw Place	

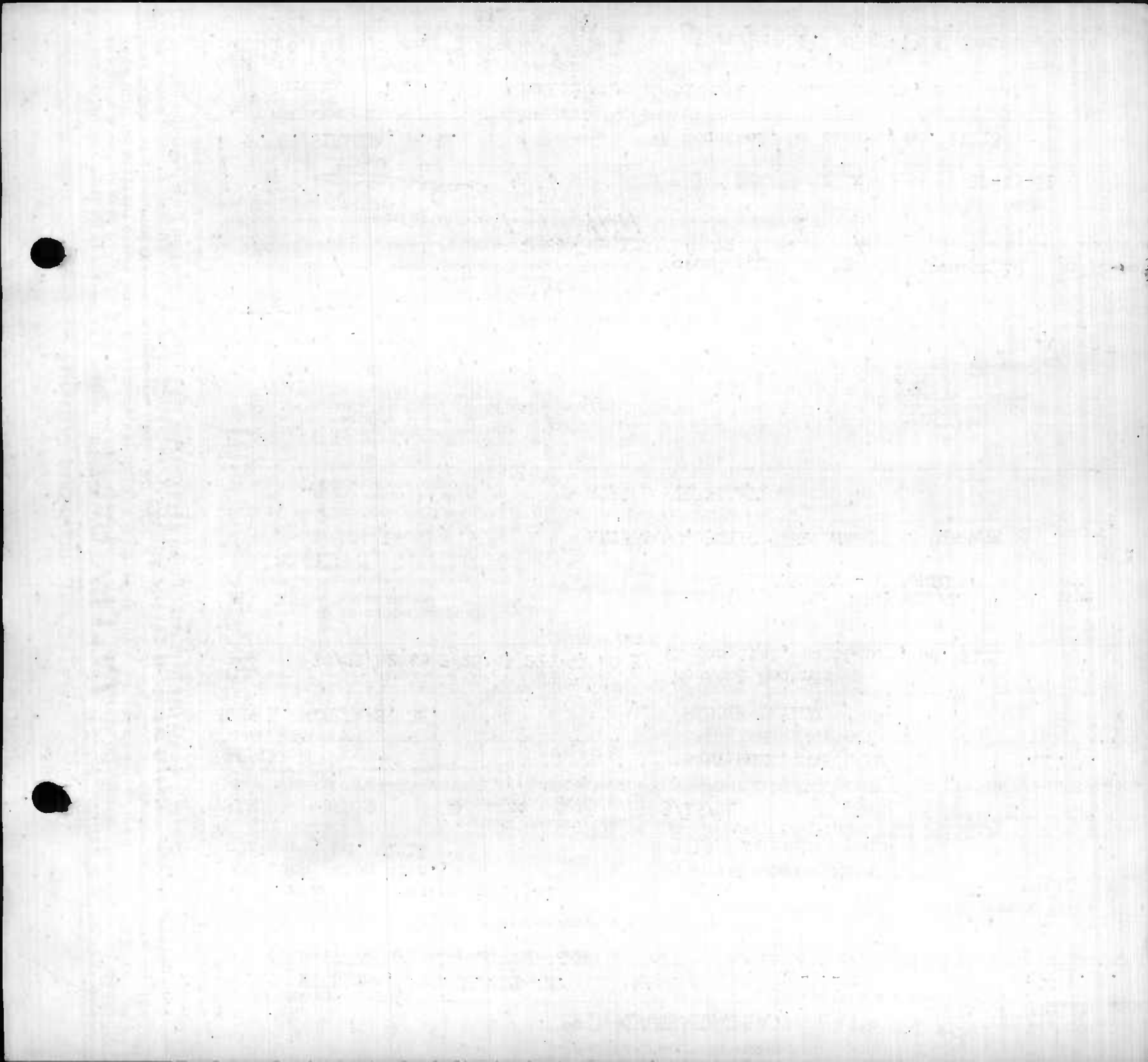




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 11910</b>	
BIRTH NO. <b>72 11910</b>				STATE OF MARYLAND-DEMD	
1. NAME OF DECEASED (Type or Print) <b>WILLIAMS, JOHN ALBERT JR.</b>			2. DATE AND HOUR OF DEATH <b>12-10-72 8:55 P. M.</b>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Veterans Administration Hospital</b> <b>3900 Loch Raven Blvd.,</b> <b>Baltimore, Md. 21218</b>			<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1537</b> <b>C. CITY OR TOWN</b> <b>BALTIMORE</b> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <b>3219 Mondowmin Avenue</b>		
<b>5. SEX</b> <b>MALE</b>		<b>6. RACE</b> <b>NEGRO</b>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>PORTER</b>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b>		<b>8. DATE OF BIRTH</b> <b>3/15/04</b>	
<b>13. FATHER'S NAME</b> <b>JOHN A. WILLIAMS, SR.</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>BESSIE TAYLOR</b>		<b>9. AGE</b> (In years last birthday) <b>68</b>	
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>YES 10/21/42 to 2/26/43</b>		<b>16. SOCIAL SECURITY NO.</b> <b>220 03 40 37</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>BALTIMORE, MARYLAND</b>	
<b>17. INFORMANT</b> <b>Medical Records</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>		<b>ADDRESS</b> <b>VA Hospital, Baltimore, Md. 21218</b>	
<b>18. CAUSE OF DEATH</b> <b>412.41</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>GROSS (R) MIDDLE CEREBRAL ARTERY 8 days</b> <b>INFARCT - EMBOLIC</b> <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE 20 years</b> <b>ATRIAL FIBRILLATION</b>			<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>		
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>					
<b>19A. DATE OF OPERATION</b> <b>NONE</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY? (Yes or No)</b> <b>YES</b>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <b>NO</b>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (APPROX.) (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (y) (this hospital) attended the deceased from November 20 19 72 to December 10 19 72, that (y) (we) last saw the deceased alive on December 10 19 72 and that in (y) (our) opinion death occurred on the date and hour and from the causes stated above. (y) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> 				<b>23B. DATE SIGNED</b> <b>12-13-72</b>	
<b>23C. PHYSICIAN'S NAME (Type)</b> <b>F. G. MIRANDA, M. D.</b>				<b>23D. ADDRESS</b> <b>VA Hospital, Baltimore, Md. 21218</b>	
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>24B. DATE</b> <b>12/18/72</b>		<b>24C. NAME OF CEMETERY OR CREMATORY</b> <b>Baltimore Nationalog</b>	
<b>24D. LOCATION</b> (City, town, or county) (State) <b>Baltimore, Maryland</b>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>DEC 18 1972</b>			
<b>25B. NAME OF REGISTRAR</b> 		<b>25C. FUNERAL DIRECTOR</b> <b>Charles A. Rice 1300 Eutaw Place</b>			



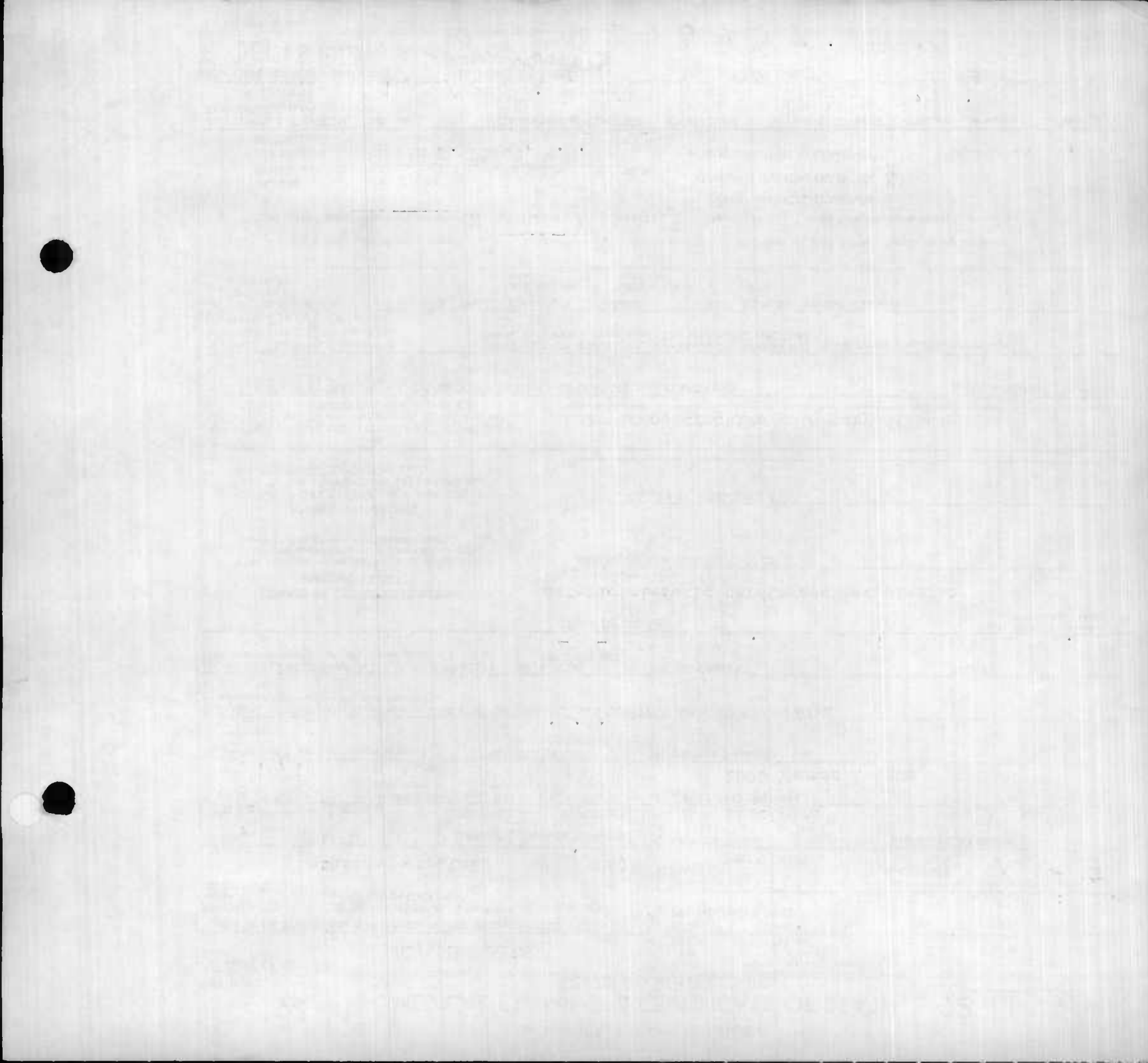
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

STATE OF MARYLAND-DEPT

REG. NO.

1. NAME OF DECEASED (Type or Print) CLIFTON TAYLOR		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> December 16, 1972 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Lutheran Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour December 16, 1972 5:50 A.M.	
6. SEX Male	7. RACE Negro	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore
9. DATE OF BIRTH 5/19/14		10. AGE (In years lost birthday) 58	D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	E. STREET AND NUMBER 1600 Thomas Avenue
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		15. MOTHER'S MAIDEN NAME LYDIA	13. FATHER'S NAME WILLIAM TAYLOR
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO. 223-24-7766	18. INFORMANT MARY E. BARNES
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
Chronic obstructive pulmonary disease		(C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Marvin S. Platt, M.D.		DATE SIGNED December 16, 1972	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/20/72	
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 18 1972		25B. NAME OF REGISTRAR Charles A. Rice	
25C. FUNERAL DIRECTOR Charles A. Rice		ADDRESS 1300 Eutaw Place	



1  
P-652

72 11912

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 11912  
REG. NO.

BIRTH NO.		STATE OF MARYLAND	
1. NAME OF DECEASED (Type or Print) Jacob Prince ELDER PRINCE		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Lutheran Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 10 1972 8:03p M.	
6. SEX male		7. RACE negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 8/20/09		10. AGE (In years last birthday) 63	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unk.		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1901	
15. MOTHER'S MAIDEN NAME Vera Prince		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 218-07-2899		18. INFORMANT Mary Prince 842 Edmondson Ave	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Gunshot wound of chest (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 1200 blk. Edmondson Ave.		22D. TIME (Month) (Day) (Year) (Hour) (Approx.) 12-10-72 7:01p m.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Shot by unknown assailants.	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12-11-72 ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell S. Fisher, M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/16/72	
24C. NAME OF CEMETERY or CREMATORY Md. National Mem. Park		24D. LOCATION (City, town, or county) (State) Laurel Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 18 1972		25B. NAME OF REGISTRAR Sidney H. [Signature]	
25C. FUNERAL DIRECTOR Charles O. Rice		25D. ADDRESS 1300 Eutaw Place	





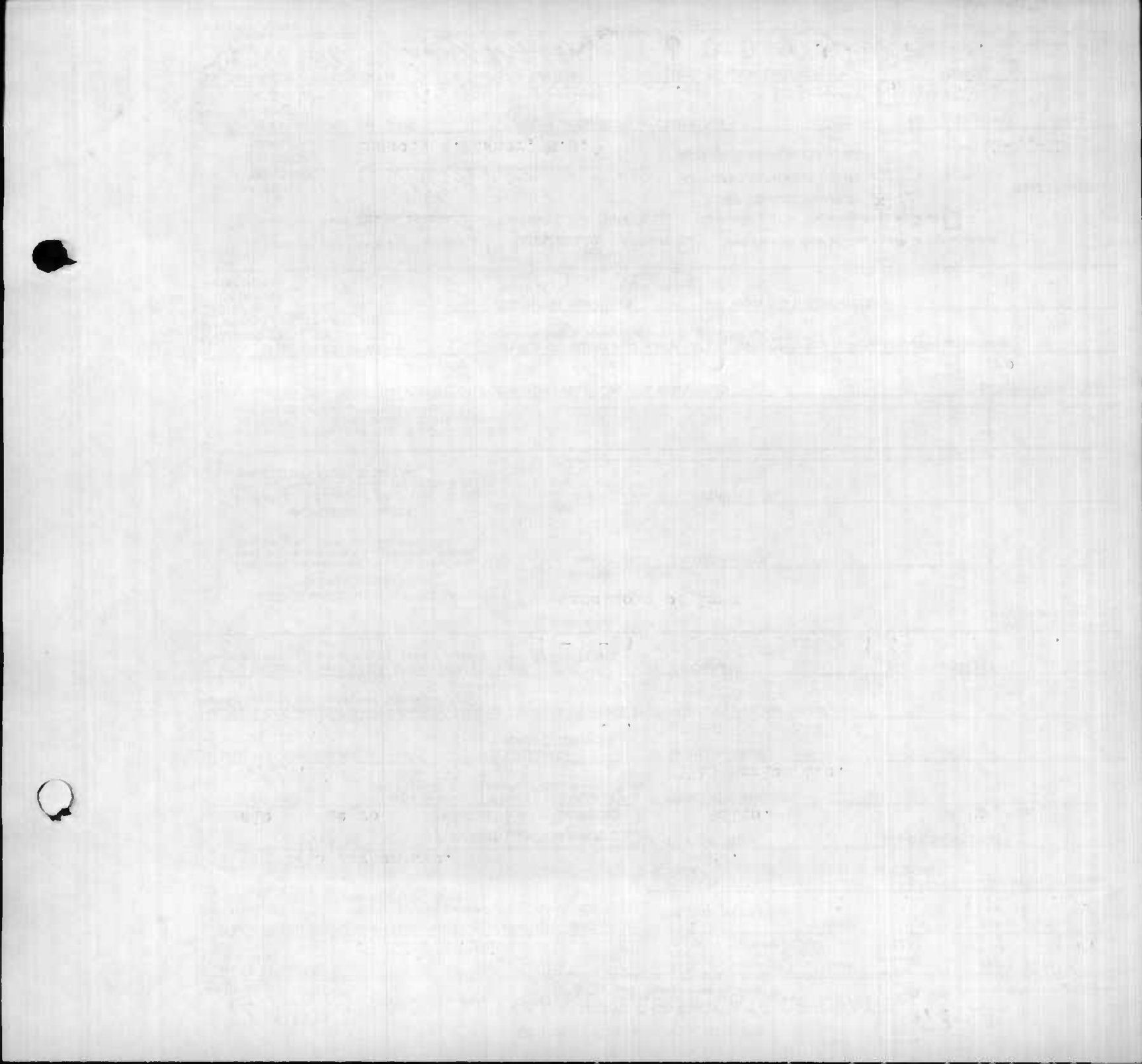
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>JAMES SPARROW</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Month Day Year 12 10 1972		Hour 4:55p	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 1713 Harlem Ave.		3. DATE PRONOUNCED DEAD Month Day Year 12 10 1972		Hour 4:55p	
6. SEX male		7. RACE negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 4/2/1897		10. AGE (In years last birthday) 75		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Moses Sparrow		14. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission) A. STATE Md. B. COUNTY 1603	
15. MOTHER'S MAIDEN NAME Martha		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI		17. SOCIAL SECURITY NO. 214-03-7187	
18. INFORMANT Gladys Jones		19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Carcinoma of lung ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <i>Russell S. Fisher</i> M.D. EXAMINER'S NAME (Type): Russell S. Fisher, M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: 12-11-72					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec 16 72		24C. NAME OF CEMETERY or CREMATORY Roosevelt Mem. Park	
24D. LOCATION (City, town, or county) (State) Norfolk, Virginia		25A. DATE REC'D BY HEALTH DEPT. DEC 18 1972		25B. NAME OF REGISTRAR <i>Lidney</i>	
25C. FUNERAL DIRECTOR Charles A. Rice		25D. ADDRESS 1300 N. Eutaw Place			





1

S-120

72 11914

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND-DEWH

REG. NO. 72 11914

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Nettie Savage

2. DATE  
OF  
DEATHKnown ☒ Estimated ☐Month  
Day  
Year12  
9  
72

Hour

10:10A. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF  
HOSPITAL  
OR INSTITUTION  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

1842 W. Baltimore St.

3. DATE  
PRONOUNCED DEADMonth  
Day  
Year12  
9  
72

Hour

10:10A. M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE B. COUNTY

Maryland

2001

6. SEX

Female

7. RACE

Negro

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

4/5/10

10. AGE (In years  
last birthday)

62

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

1842 W. Baltimore St.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

William Parson

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Julia V. Garner

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL  
SECURITY NO.

214-20-8847

18. INFORMANT

ADDRESS

Evelyn Curtis 2816 Oswego Ave.

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) IMMEDIATE CAUSE Arteriosclerotic cardiovascular  
DUE TO, OR AS A CONSEQUENCE OF: diseaseANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF:

(C) \_\_\_\_\_

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)W P Mulloy M.D.  
William P. Mulloy, M.D.CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-10-72

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

12/13/72

24C. NAME of CEMETERY or CREMATORY

Mt. Auburn

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

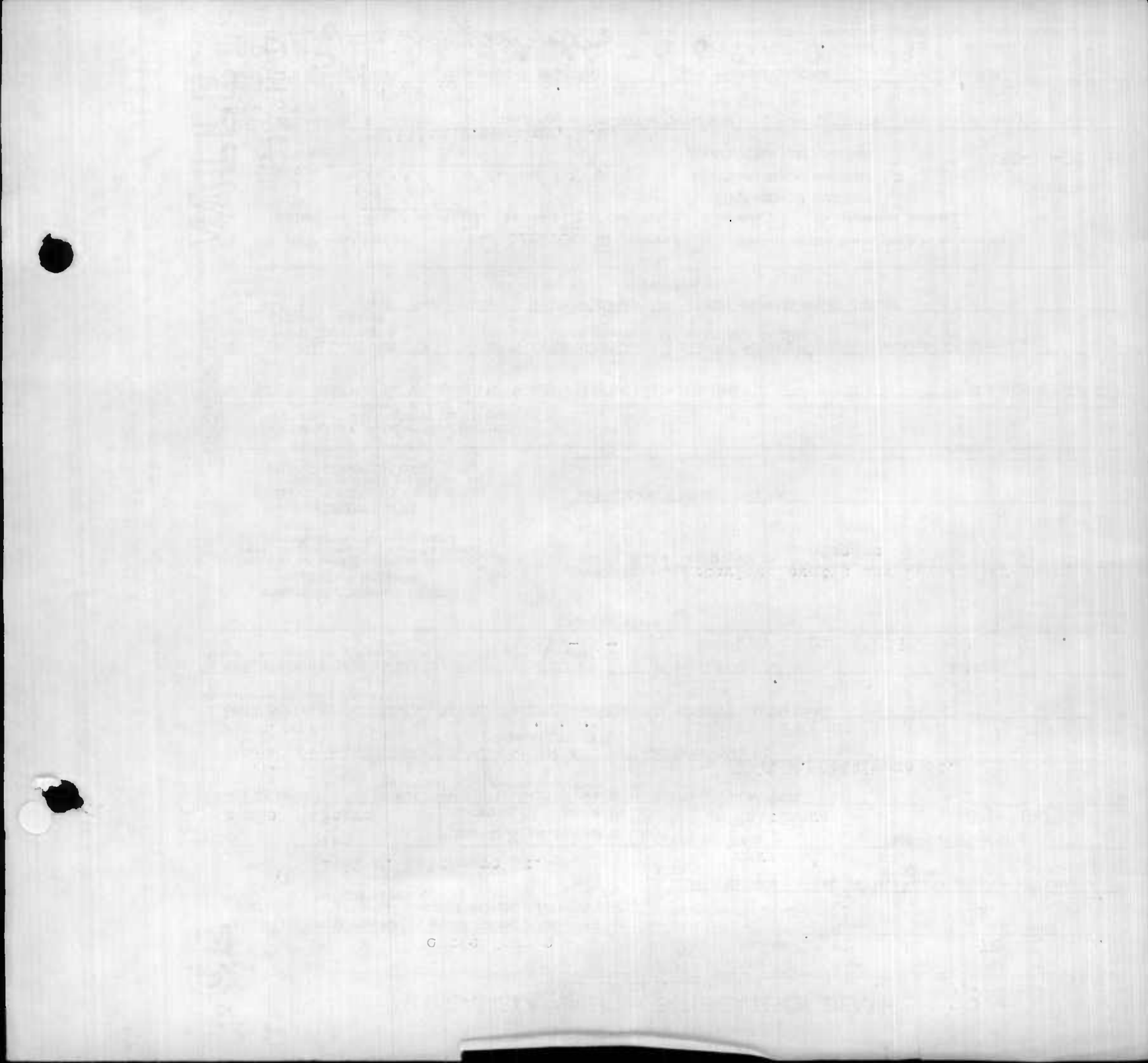
ADDRESS

DEC 18 1972

Sidney Houston

Charles D. Rice

1300 Eutaw Place



## 72 11915 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JAMES SMITH

2. DATE  
OF  
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
HOSPITAL ADDRESS OR LOCATION)

Lutheran Hospital (DOA)

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md.

B. COUNTY

1502

6. SEX

male

7. RACE

negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

9/3/47

10. AGE (In years  
last birthday)

25

11. Under 1 Yr. 12 Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

1818 N. Mount St.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

James Smith

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Factory Worker

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Dorothy Levroney

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL  
SECURITY NO.

218-44-6688

18. INFORMANT

ADDRESS

Dorothy Smith 254 Robert St.

19.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

Gunshot wounds of chest

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)

street

22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

1100 blk. Longwood St.

22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.)

12-10-72

8:02 p.m.

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Shot by unknown assailant.

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Peter Lipkovic, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-11-72

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

12/15/72

24C. NAME of CEMETERY or CREMATORY

Mt. Calvary Cemetery

24D. LOCATION

(City, town, or county)

(State)

Brooklyn, Maryland

25A. DATE REC'D BY HEALTH DEPT.

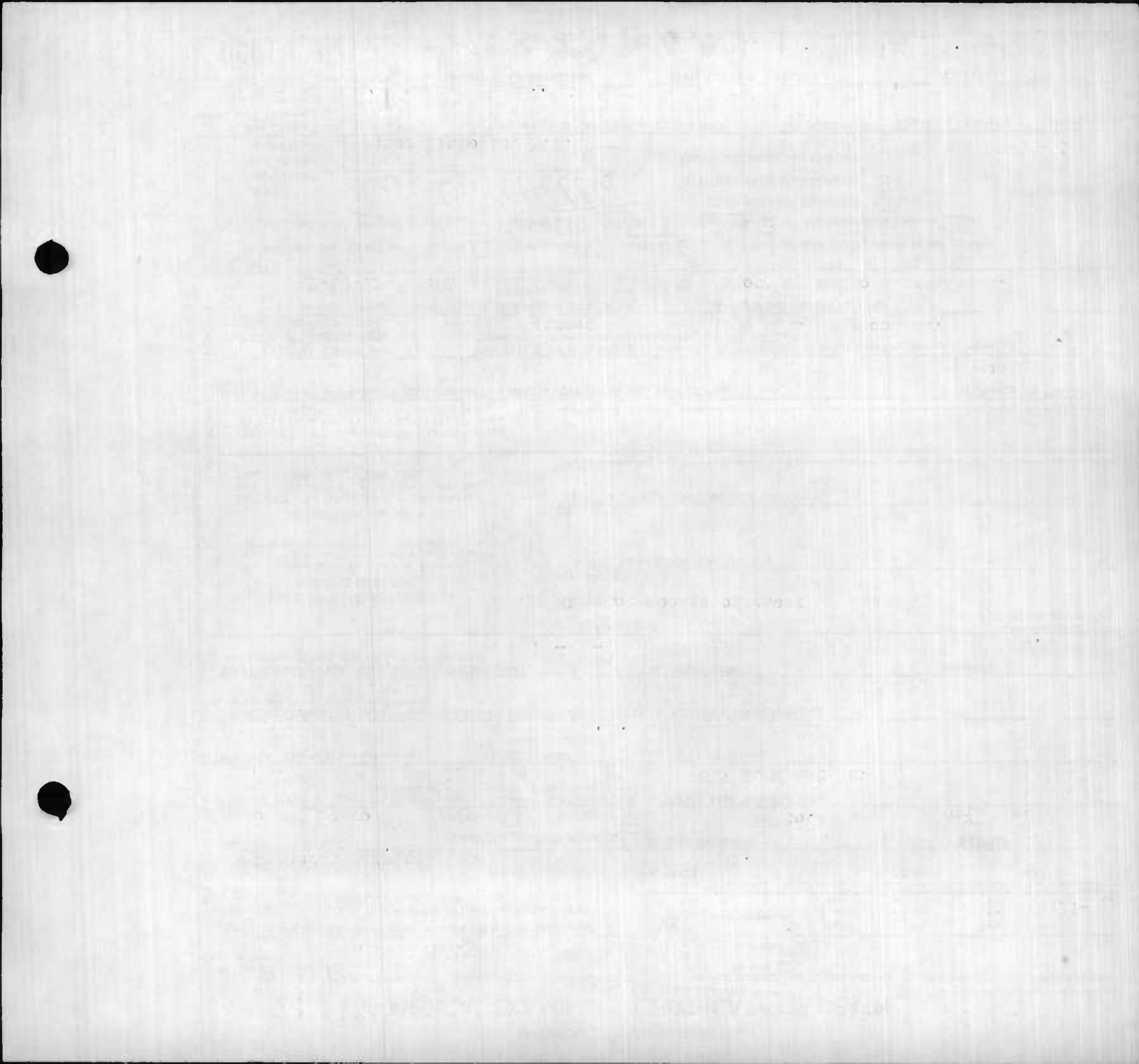
DEC 18 1972

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

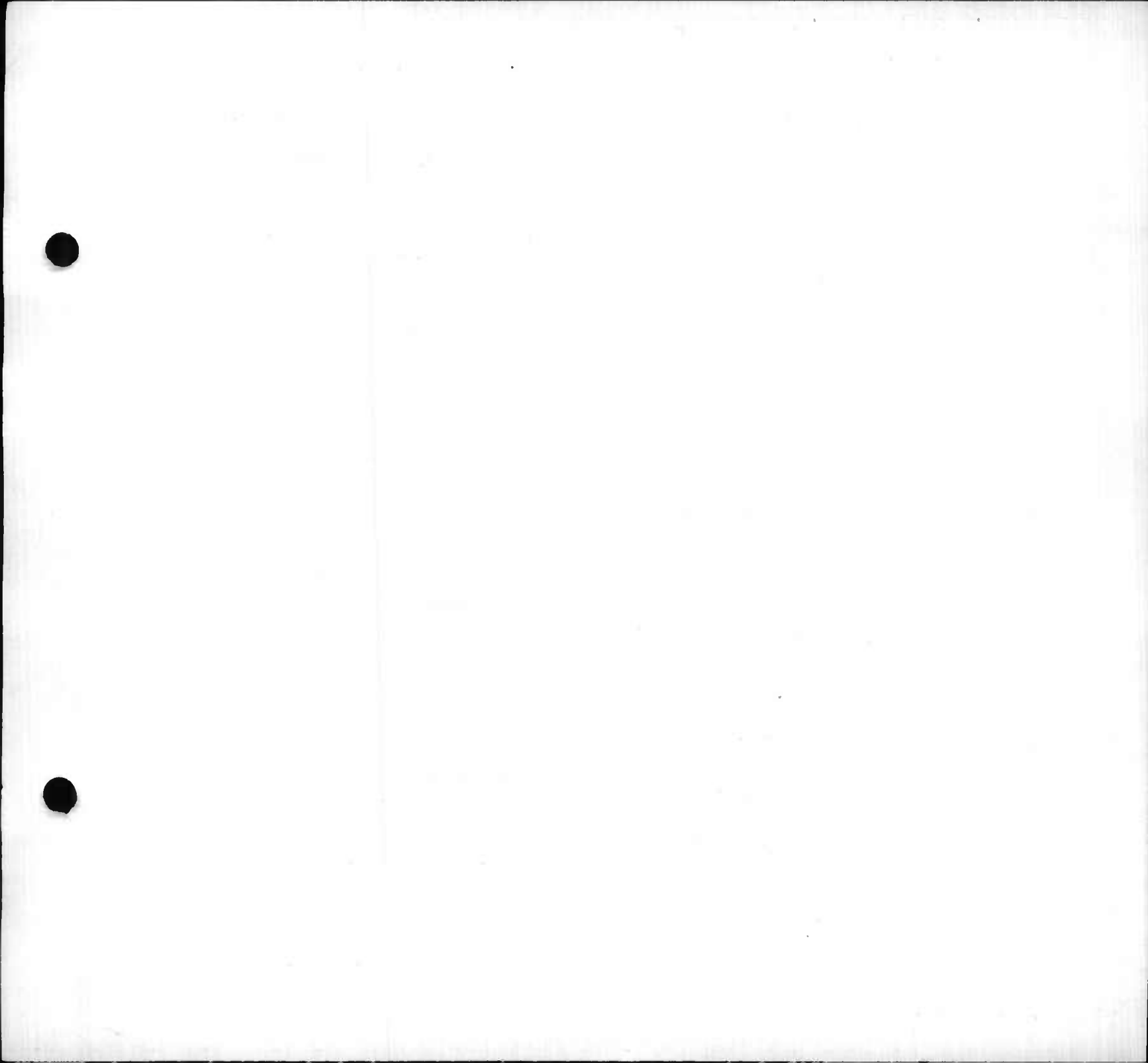
ADDRESS

Charles A. Rice 1300 N. Eutaw Place



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician pronounced death in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 11916	
72 11916 CERTIFICATE OF DEATH					
STATE OF MARYLAND-DEATH					
BIRTH NO. 72 11916		1. NAME OF DECEASED (Type or Print) SARAH PARKER			
2. DATE AND HOUR OF DEATH 12/12/72 13:05 A.M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIVERSITY OF MD HOSPITAL			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY BALTIMORE		C. CITY OR TOWN BALT. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX F 6. RACE BLACK 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-29-79 9. AGE (in years last birthday) 94			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Louis Deal		14. MOTHER'S MAIDEN NAME Sarah E. Causter			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Berdella Love 1222 Bayard Street	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 486X I CARDIO - RESPIRATORY ARREST (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: PNEUMONIA (B) DUE TO, OR AS A CONSEQUENCE OF: (C) ASCUD		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 min. 4 days			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-8-72 to 12-12-72 that (I) (we) last saw the deceased alive on 12-12-72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Michael A. Moskewicz		23B. DATE SIGNED 12/12/72		23C. PHYSICIAN'S NAME (Type) MICHAEL A. MOSKEWICZ	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/15/72		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery	
25A. DATE REC'D BY HEALTH DEPT. DEC 18 1972		25B. NAME OF REGISTRAR Siding in hospital		25C. FUNERAL DIRECTOR Charles A. Rice 1300 N. Eutaw Place	





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 11917		REG. NO. 72 11917	
BIRTH NO. 72 11917				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>JAMES GASKINS</b>				2. DATE AND HOUR OF DEATH <b>12/11/72 1 50 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>THE JOHNS HOPKINS HOSPITAL</b> <b>33</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1303</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2518 DRUID HILL AVE.</b>			
5. SEX <b>MALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-31-95</b>		9. AGE (In years lost birthday) <b>77</b>	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>JAMES GASKINS</b>				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>219-05-8943</b>		17. INFORMANT ADDRESS <b>James C. Gaskins Jr. 2518 Druid Hill</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>579.21</b> <b>CAUSE OF DEATH</b> <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <b>CARDIO-RESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>ACUTE RESPIRATORY FAILURE</b> <b>1 week</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>CHRONIC LUNG DISEASE</b> <b>20 yrs.</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <b>2</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>(1)</u> (this hospital) attended the deceased from <b>Dec 3</b> 19 <b>72</b> to <b>Dec 11</b> 19 <b>72</b> , that <u>(1)</u> (we) last saw the deceased alive on <b>Dec 11</b> 19 <b>72</b> and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(1)</u> (we) (did) (did not) view the body after death.							
23A. SIGNATURE <b>K. Osborne M.D.</b>				23B. DATE SIGNED <b>12/11/72</b>		23C. PHYSICIAN'S NAME (Type) <b>K. OSBORNE, M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>12/15/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Baltimore Nat'l Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>				25A. DATE REC'D BY HEALTH DEPT. <b>DEC 18 1972</b>			
25B. NAME OF REGISTRAR <b>Sidney M. Houston</b>				25C. FUNERAL DIRECTOR ADDRESS <b>Charles A. Rice 1300 N. Eutaw Place</b>			

STATE OF ...

...

...

...

...

...

...

...

...

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 72 11918		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 11918	
1. NAME OF DECEASED (Type or Print) <u>Pennington, Etheldra</u>			2. DATE AND HOUR OF DEATH <u>12-12-72</u> <u>1500</u> AM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>PA</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>39</u> <u>Provident Hospital, Inc.</u> <u>2600 Liberty Height Ave.</u> <u>Baltimore, Md. 21215</u>			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-10-09</u>	9. AGE (in years last birthday) <u>63</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>John Payn</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>218-12-4200</u>		17. INFORMANT <u>Marie Hollie (Granddaughter)</u> Same
18. <u>560.91 + 250.9</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  19A. DATE OF OPERATION <u>0</u>			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Fluid-Electrolyte Imbalance</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Infection Obstruction Diabetes Mellitus, severe</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>December 10, 1972</u> to <u>December 12, 1972</u> that (I) (we) last saw the deceased alive on <u>December 12, 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>G. Ioot, M.D.</u>			23B. DATE SIGNED <u>December 12, 1972</u>		23C. PHYSICIAN'S NAME (Type) <u>G. Ioot, M.D.</u>
24A. BURIAL CREMATION, 24B. DATE REMOVAL (Specify) <u>Burial</u> <u>12/16/72</u>			24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 18 1972</u>		25B. NAME OF REGISTRAR <u>Andrew H. Horton</u>		25C. FUNERAL DIRECTOR <u>Charles A. Rice</u> 1300 Eutaw Place	

472 MANSE CT  
J.E. Ruff

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

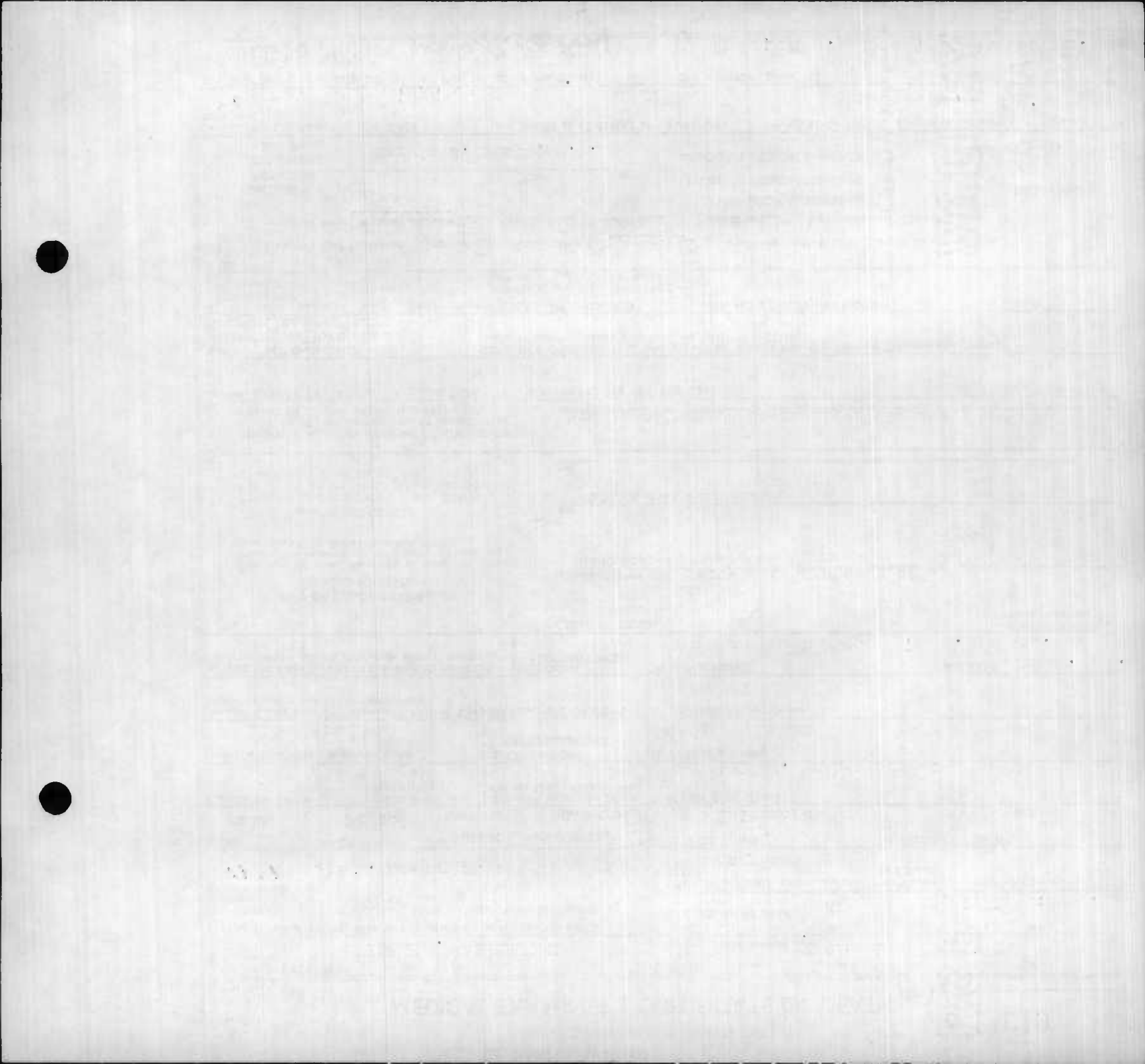
1. NAME OF DECEASED (Type or Print) <b>WILLIE R. WASHINGTON</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> December 12, 1972 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>00 1329 W. Mosher Street</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour December 13, 1972 1:50 P. M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (in years last birthday) 40		E. STREET AND NUMBER 1329 W. Mosher Street	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Joseph Washington		14. USUAL RESIDENCE (Where deceased lived, if Institution; residence before admission) A. STATE Maryland B. COUNTY 1602	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME Rebecca Washington	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO.	
18. INFORMANT Rebecca Washington		ADDRESS Phila. Pa. 716 S. 66 St.	

19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Chronic pulmonary obstructive disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE Fatty metamorphosis of liver DUE TO, OR AS A CONSEQUENCE OF:			
(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:			

20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	

23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Marvin S. Platt, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED December 14, 1972	
		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			

24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/16/72		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 18 1972		25B. NAME OF REGISTRAR Johnny B. [Signature]		25C. FUNERAL DIRECTOR Charles A. Rice		ADDRESS 1300 Eutaw Pl.	





W-220 1

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 11920		REG. NO. 72 11920	
BIRTH NO.				STATE OF MARYLAND - DHMH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
GLADYS M. WISCOSKEY				12-13-72 6:30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE		B. COUNTY	
34 BON SECOUR HOSPITAL				MD.		2102	
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				1347 JAMES STREET - BALTO. 21223			
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
F		W		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		1-19-02	
						9. AGE (In years last birthday)	
						70	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
HOUSEWIFE						MARYLAND	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
WILLIAM PARKS				ANNA -			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
						MRS. GLORIA M. MICHALSKI 1331 JAMES ST. 21223	
18. 410.0 I				CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				(B) Hypertensive Cardiac Vasculature			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				DUE TO, OR AS A CONSEQUENCE OF:			
				(C).....			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 9-4 1973 to 12-13 1972, that (I) (we) last saw the deceased alive on 12-6 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
John P. Urlock Jr. M.D.				12-15-72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
DR. JOHN URLOCK, JR.				1227 WASHINGTON BLVD.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		12-18-72		LOUDON PARK CEMETERY		BALTIMORE MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
DEC 18 1972		Audrey W. Hinton		HUBBARD FUNERAL HOME, INC.		4107 WILKENS AVE	



117

117

117

117

117

117

117

117

117

117

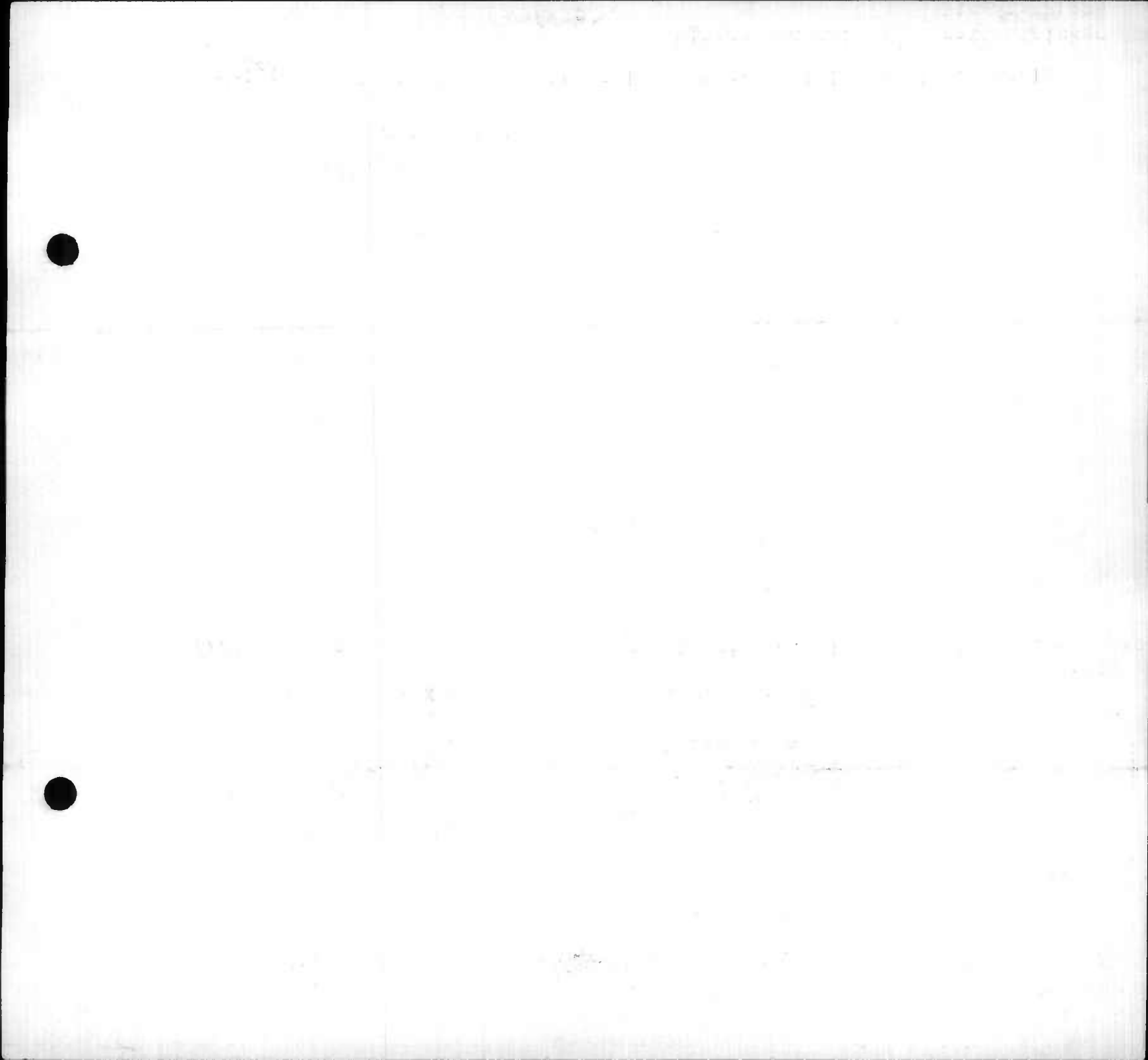
117

117

117

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. 72 11921	
BIRTH NO. 72 11921				STATE OF MARYLAND - DIME			
1. NAME OF DECEASED (Type or Print) FLAHAVEN, REV. MARTIN W.				2. DATE AND HOUR OF DEATH 12/14/72 9:01PM 9:01 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BON SECOURS HOSPITAL 2025 FAYETTE ST. BALTO. MD. 21223				4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE MARYLAND B. COUNTY BALTO C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 612 "D" ST. ST. LUKE'S RECTORY			
5. SEX M		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/11/17	
9. AGE (In years last birthday) 55 YRS		10. UNDER 1 Yr. Months Days		11. UNDER 24 Hrs. Hours Min.		12. CITIZEN OF WHAT COUNTRY? USA	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRIEST				10B. KIND OF BUSINESS OR INDUSTRY CLERGYMAN			
13. FATHER'S NAME JOHN J. FLAHAVEN				14. MOTHER'S MAIDEN NAME LOURETTA Touhey			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) XXXXXXX No				16. SOCIAL SECURITY NO. 215-48-4607		17. INFORMANT Catherine L. Flahavan 4818 Edmondson Ave	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Indicate medical condition)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11-20-1972 to 12-14-1972 that (I) (we) last saw the deceased alive on 12/14/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Sheddi, M.D.				23B. DATE SIGNED 12-14-72			
23C. PHYSICIAN'S NAME (Type) ABEDI M.D.				23D. ADDRESS BON SECOURS Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/18/72		24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore City, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 18 1972		25B. NAME OF REGISTRAR Sidney [Signature]		25C. FUNERAL DIRECTOR Walters Funeral Home Pratt & Stricker		ADDRESS Streets 21223	



1  
B-246

72 11922

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 11922

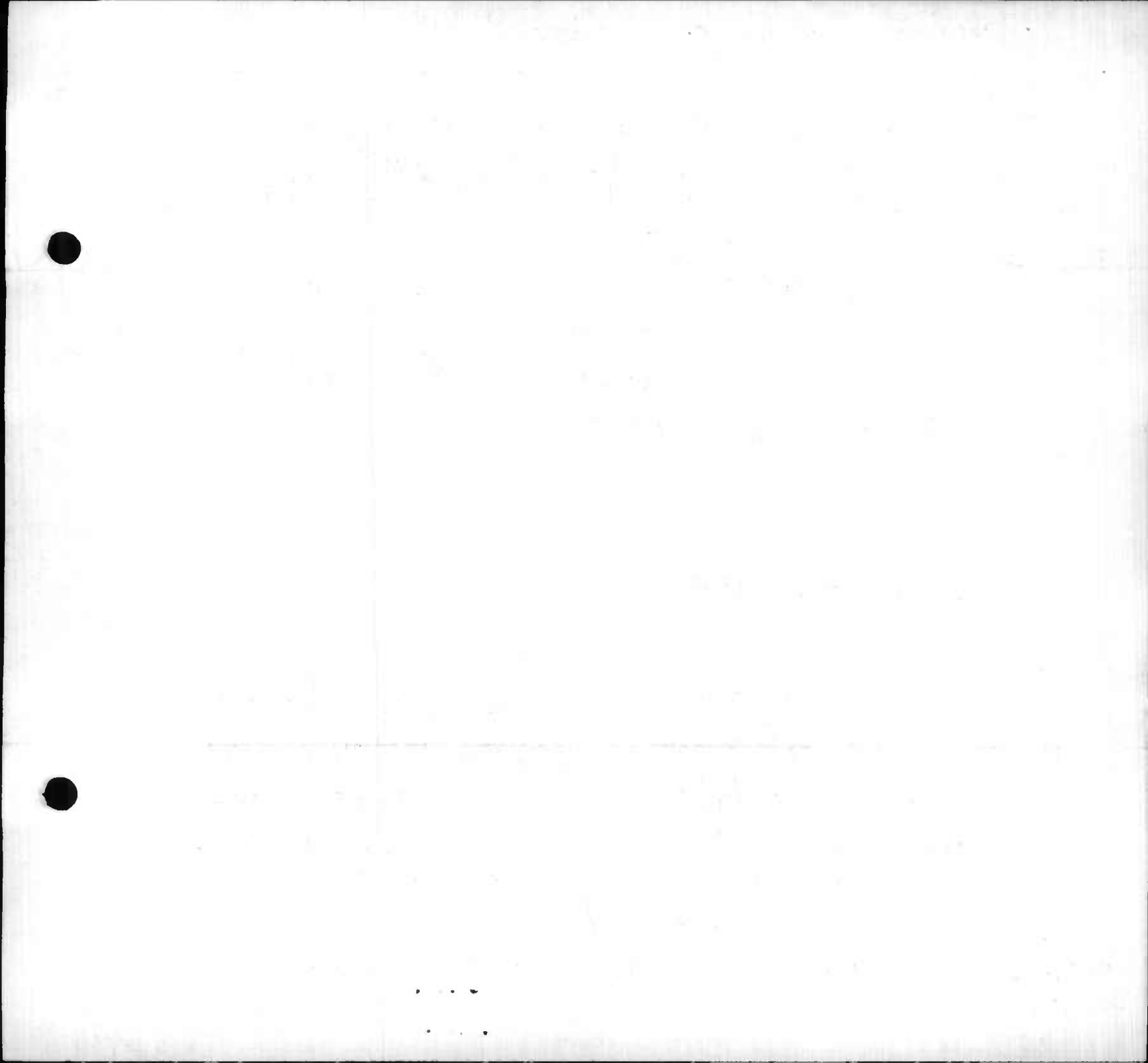
BIRTH NO.		STATE OF MARYLAND - DEPT.		REG. NO.	
1. NAME OF DECEASED (Type or Print) C. William Buckler		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year 12 13 72 Hour 6:10 a. M.		3. DATE PRONOUNCED DEAD Month Day Year 12 13 72 Hour 6:10 a. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 Balto. City Hospital		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY Baltimore		6. CITY OR TOWN Essex Balto. D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
6. SEX male	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. DATE OF BIRTH Aug. 17, 1900 10. AGE (In years last birthday) 72 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? What Country?	
13. FATHER'S NAME James O. Buckler		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipyard - Bethlehem Steel Co.		15. MOTHER'S MAIDEN NAME Mary G. Cusick	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 218-10-4053A		18. INFORMANT (Daughter) 1134 Foxwood Lane Mrs. Patricia Vettel, Balto. Md. 21221	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Pneumonia (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Conflagration (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 1134 Foxwood Road	
22D. TIME OF INJURY (APPROX.) 12 4 72 3:10p.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Subject in house fire.	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>		ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/13/72	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/16/72		24C. NAME of CEMETERY or CREMATORY Oak Lawn Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. DEC 18 1972		25B. NAME OF REGISTRAR Sidney H. [Signature]	
25C. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.		25D. ADDRESS			

N 94410

✓









FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-2001		72 11924		BALTIMORE CITY HEALTH DEPARTMENT		X		72 11924	
CERTIFICATE OF DEATH				REG. NO.		STATE OF MARYLAND-DEMT			
1. NAME OF DECEASED (Type or Print) <u>COOK-ROSE J.</u>				2. DATE AND HOUR OF DEATH <u>12-15-72 1:10A M.</u>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>BON SECOURS HOSPITAL</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN <u>CATONSVILLE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>6110 EDMONDSON AVE - Apt 73 - 21228</u>					
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>05/01/85</u>	9. AGE (In years last birthday) <u>87</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>LEONARD JACOB</u>				14. MOTHER'S MAIDEN NAME <u>XXXXXXXXXX</u> <u>Rose Wittig</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>219 54 3319</u>		17. INFORMANT <u>Mrs. Marie C. Lindley, 6110 B Edmondson Ave.</u>			
18. <u>412.21</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>(A) IMMEDIATE CAUSE A cute myocardial infarct + cholangitis</u> <u>(B) HANDED</u> <u>(C) Chronic cholangitis.</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION <u>12-1-72</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>sept. hep. liver biopsy</u>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>Nov 21</u> 19 <u>72</u> to <u>December 15</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>11:00AM 12-15-1972</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>A. Naberi, M.D.</u>				23B. DATE SIGNED <u>12-15-72</u>				23C. PHYSICIAN'S NAME (Type) <u>ABAN NABERI-GHOVCHANI MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>12-18-1972</u>		24C. NAME of CEMETERY or CREMATORY <u>Druid Ridge Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Pikesville, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 18 1972</u>				25B. NAME OF REGISTRAR <u>Edw. H. Hubbard</u>		25C. FUNERAL DIRECTOR <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u>			

100000

100000

100000

100000

100000

100000

FUNERAL DIRECTOR: IMPORTANT

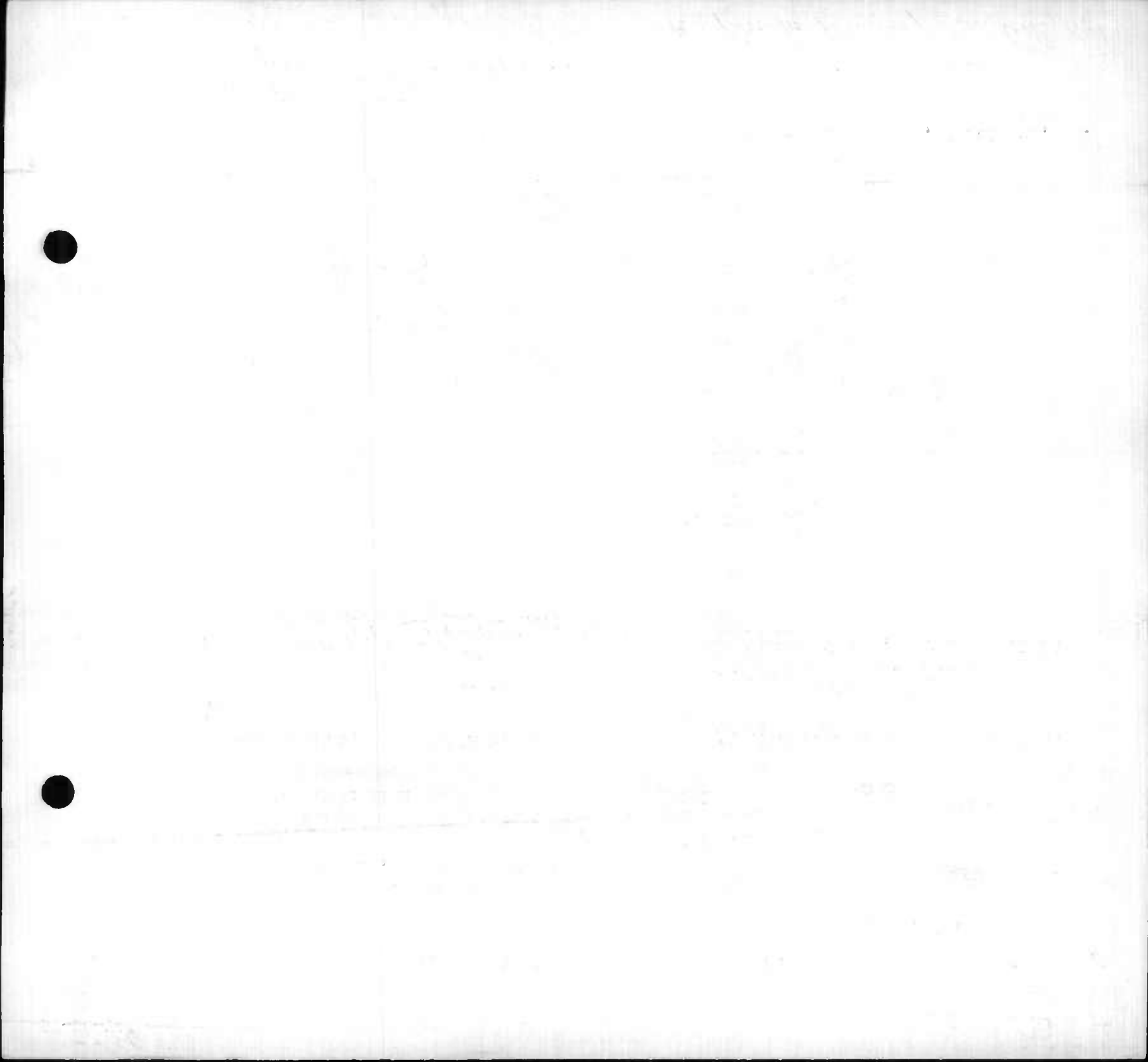
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-100 1		72 11925		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 11925	
CERTIFICATE OF DEATH				STATE OF MARYLAND-DHMH			
1. NAME OF DECEASED (Type or Print)		Charles E. Kapp		2. DATE AND HOUR OF DEATH		12/14/72 9:55 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
University of Maryland Hospital		38		Maryland		Baltimore	
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
M		W		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		10-28-1902	
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
70		Mechanic		Maryland		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Samuel Kapp				Genevieve McCannon			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
Yes		WWI		219-18-0955		Mrs. Evelyn East, 611 S. Smallwood St. #23	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		About one year	
ANTECEDENT CAUSES				(B) Cancer of the maxilla DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
10/17/72		poor		No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 10/11 1972 to 12/14 1972 that (I) (we) lost saw the deceased alive on 12/14 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Young C. Shin M.D.				12/14/72			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		23E. FUNERAL DIRECTOR		ADDRESS	
Young C. Shin M.D.		8373 Morven Rd. Baltimore, MD. 21234		Hubbard Funeral Home		4107 Wilkens Ave.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		12-19-72		Moreland Memorial Park		Balto. County Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
DEC 18 1972		[Signature]		Hubbard Funeral Home		4107 Wilkens Ave.	

1000

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 72 11926		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 72 11926	
CERTIFICATE OF DEATH		STATE OF MARYLAND-DMH			
1. NAME OF DECEASED (Type or Print) <b>WALTER WADE SNYDER</b> <i>Snyder, Walter ER</i>		2. DATE AND HOUR OF DEATH <b>12/11/72</b> <i>5:50 P.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>4940 Eastern Avenue</b> <i>31 Baltimore City Hospital</i> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? <b>NO</b> E. STREET AND NUMBER <b>3105 Ardee Way</b>			
5. SEX <b>Male</b>	6. RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/5/19</b>	9. AGE (In years last birthday) <b>53</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MACHINIST</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>STEEL MFR.</b>		11. BIRTHPLACE (State or (foreign country) <b>PENNSYLVANIA</b>	
13. FATHER'S NAME <b>DARIUS SNYDER</b>		14. MOTHER'S MAIDEN NAME <b>OPAL CONN</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES-KOREA 9/7/46-6/3/47</b>		16. SOCIAL SECURITY NO. <b>213-18-7087</b>		17. INFORMANT <b>4940 Eastern Avenue</b> ADDRESS <b>BCH RECORDS: Baltimore, Maryland 21224</b>	
18. <b>42571</b> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <b>CARDIAC Failure</b> DUE TO, OR AS A CONSEQUENCE OF: <b>congestive Heart Failure</b> <b>cardiomyopathy</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>CARDIO MYOPATHY</b> (C) <b>Serious Infection</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>None</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>None</b>		20A. AUTOPSY? (Yes or No) <b>None</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>None</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>None</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>None</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>None</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>None</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>11-24</b> <b>12/11/72</b> to <b>12/11/72</b> 19 <b>72</b> and that (I) (we) lost saw the deceased alive on <b>12/11/72</b> 19 <b>72</b> and that (I) (we) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Richard L. Saylor</b>		23B. DATE SIGNED <b>12/11/72</b>		23C. PHYSICIAN'S NAME (Type) <b>Richard L. Saylor</b>	
24A. BURIAL OR CREMATION <b>BURIAL</b>		24B. DATE <b>12/15/1972</b>		24C. NAME OF CEMETERY OR CREMATORY <b>OAK LAWN</b>	
24D. LOCATION (City, town, or county) <b>BALTO. Co, Md.</b>		24E. ADDRESS <b>4940 Eastern Avenue, Baltimore, Md.</b>		24F. CITY OR TOWN <b>BALTIMORE</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 18 1972</b>		25B. NAME OF REGISTRAR <b>Lidney Wootton</b>		25C. FUNERAL DIRECTOR <b>W. Proctor Bradley Dunlock, Md.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72 11927</u> STATE OF MARYLAND-DEPT	
BIRTH NO. <u>72 11927</u>					
1. NAME OF DECEASED (Type or Print) <u>ALLISON, GLEN N</u>		2. DATE AND HOUR OF DEATH <u>DECEMBER 12, 1972</u>   <u>5:20</u> P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>VETERANS ADMINISTRATION HOSPITAL</u> <u>3900 LOCH RAVEN BOULEVARD</u> <u>BALTIMORE, MARYLAND 21218</u>		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>MALE</u>		6. RACE <u>CAUCASIAN</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ENGINEER (Retired)</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Penna R. R.</u>		8. DATE OF BIRTH <u>5-24-96</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>		9. AGE (In years last birthday) <u>76</u>		12. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u>	
13. FATHER'S NAME <u>CLINTON ALLISON</u>		14. MOTHER'S MAIDEN NAME <u>CLARA PEACOCK</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>5-3-18 to 9-30-21</u>		16. SOCIAL SECURITY NO. <u>705-10-00-40</u>		17. INFORMANT <u>VA HOSPITAL RECORDS</u> <u>3900 LOCH RAVEN BLVD, BALTIMORE, MD 21218</u>	
18. <u>156.21</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CARCINOMA AROUND AMPULA OF WATER</u>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>METASTASIS TO LIVER, PANCREAS</u>			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>76</u> (this hospital) attended the deceased from <u>NOVEMBER 28</u> 19 <u>72</u> to <u>DECEMBER 12</u> 19 <u>72</u> , that <u>76</u> (we) last saw the deceased alive on <u>DECEMBER 12</u> 19 <u>72</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>76</u> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Jonathan L. Shurberg M.D.</u>				23B. DATE SIGNED <u>12/12/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>JONATHAN L. SHURBERG M.D.</u>				23D. ADDRESS <u>3900 LOCH RAVEN BLVD. BALTO., MD.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/15/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>St. Marys Cem (Hampden)</u>	
24D. LOCATION <u>Baltimore, Maryland</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 18 1972</u>		25B. NAME OF REGISTRAR <u>Andrew H. Hooton</u>		25C. FUNERAL DIRECTOR <u>G. Alan Seitz, Jr.</u>	
25D. ADDRESS <u>3818 Roland Ave.</u>					





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.2em;">72 11928</span>	
BIRTH NO. <span style="font-size: 1.2em;">72 11928</span>				STATE OF MARYLAND - DEPT.	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
CELYA J. ROBINSON			DECEMBER 12, 1972		7:01 P. M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">PROVIDENT HOSPITAL</span> <span style="font-size: 2em;">39</span>			A. STATE MARYLAND		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 2601 MADISON AVENUE #21217		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/25/1887	9. AGE (In years last birthday) 85	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NURSE		10B. KIND OF BUSINESS OR INDUSTRY HOSPITAL		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
13. FATHER'S NAME HYMAN HARRIS			12. CITIZEN OF WHAT COUNTRY? USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO.		17. INFORMANT MR. HERBERT A. ROBINSON, EDEN ROC WAY #21208
18. <span style="font-size: 1.5em;">402X</span> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">Myocardial infarction with pulmonary edema</span> (B) <span style="font-size: 1.2em;">Myocardial infarction</span> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">Sudden</span> <span style="font-size: 1.5em;">1998</span>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">June 10</span> 19 <span style="font-size: 1.2em;">31</span> to <span style="font-size: 1.2em;">July 11</span> 19 <span style="font-size: 1.2em;">72</span> , that (I) (we) lost saw the deceased alive on <span style="font-size: 1.2em;">July 11</span> 19 <span style="font-size: 1.2em;">72</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Samuel Whitehouse M.D.</span>				23B. DATE SIGNED <span style="font-size: 1.5em;">12/13/72</span>	
23C. PHYSICIAN'S NAME (Type) SAMUEL WHITEHOUSE				23D. ADDRESS 3900 N. CHARLES STREET	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/14/72		24C. NAME OF CEMETERY or CREMATORY HEBREW FRIENDSHIP	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. DEC 18 1972			
25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Sidney Robinson</span>		25C. FUNERAL DIRECTOR GOL LEVINSON & BROS. 6010 REISTERSTOWN ROAD			

1944

1945

1946

1947

1948

1949

1950

1951

1952

1  
T-125

72 11929

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

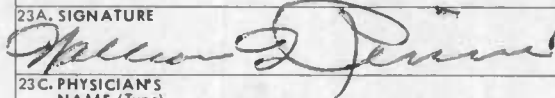
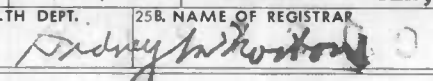
72 11929

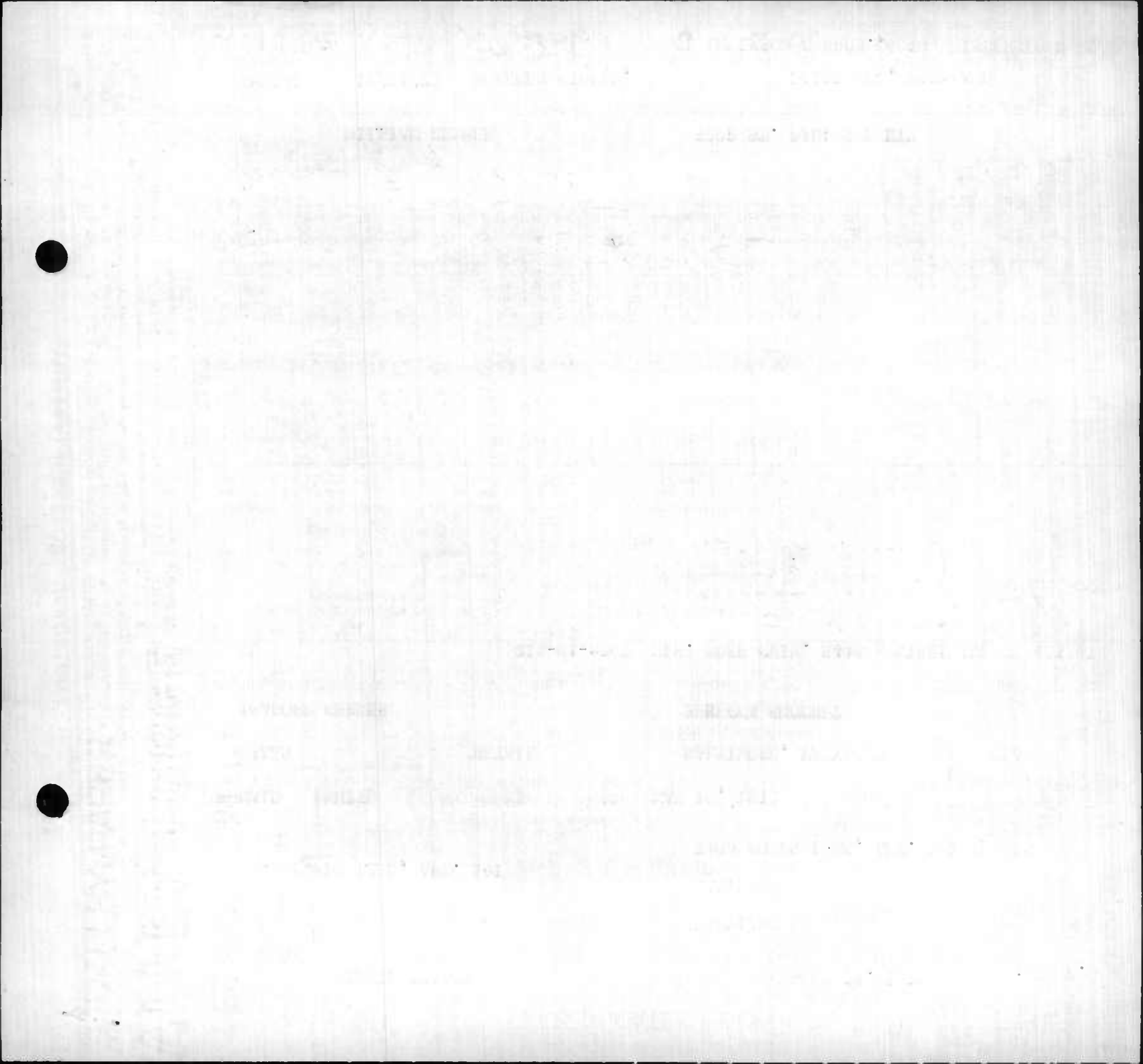
BIRTH NO.		STATE OF MARYLAND-DEPT.		REG. NO.	
1. NAME OF DECEASED (Type or Print) BENJAMIN <del>XXXX</del> Tobesman		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 12 Day 13 Year 72		Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 3000 W. Coldspring Lane		3. DATE PRONOUNCED DEAD Month 12 Day 13 Year 72		Hour 7:20 a. M.	
6. SEX male		7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH APRIL 7, 1914		10. AGE (in years lost birthday) 58		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME <del>XXXXXXXXXXXX</del> HARRY TOBESMAN		14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 1513	
15. MOTHER'S MAIDEN NAME IDA ?		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO. 218-03-4079	
18. INFORMANT MISS MARIAN TOBESMAN, 5821 JONQUIL AVE. #21215		19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <i>Peter Lipkovic</i> M.D. EXAMINER'S NAME (Type): Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: 12/13/72					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/14/72		24C. NAME of CEMETERY or CREMATORY SHAAREI ZION	
24D. LOCATION (City, town, or county) (State) ROSEDALE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. DEC 18 1972		25B. NAME OF REGISTRAR <i>Andrew Johnson</i>	
25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		25D. ADDRESS		25E. ADDRESS	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 11930</u>
BIRTH NO. <u>72 11930</u>				STATE OF MARYLAND-DEPT.
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
MINNIE ISAACS		DECEMBER 12, 1972 3:45 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY		
3900 FORDS LANE, APT. 101		MARYLAND		
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?
		BALTIMORE		YES <input type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER		
		3900 FORDS LANE, APT. 101 #21215		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)
FEMALE	WHITE	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	MAY 19, 1912	60
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
SALES		RETAIL		BALTIMORE, MARYLAND
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
ISADORE GERBER		REBECCA SHOCKET		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
NO		218-01-8762		MRS. ROSE CRIM, 5448 MONTBEL AVENUE #21207
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF		
ANTECEDENT CAUSES		Rheumatic Heart Disease with mitral lesions		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		
		(C) DUE TO, OR AS A CONSEQUENCE OF:		
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
22. I certify that (I) (this hospital) attended the deceased from 1/31/69 19 to 12/12/72 19, that (I) (we) last saw the deceased alive on 12/4 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE				23B. DATE SIGNED
				12/13/72
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
WILLIAM RENNER		3222 ST. PAUL STREET		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY
BURIAL		12/14/72		WORKMEN CIRCLE,
				BALTIMORE, MARYLAND
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS
DEC 18 1972				SOLO LEVINSON & BROS., 6010 REISTERSTOWN ROAD

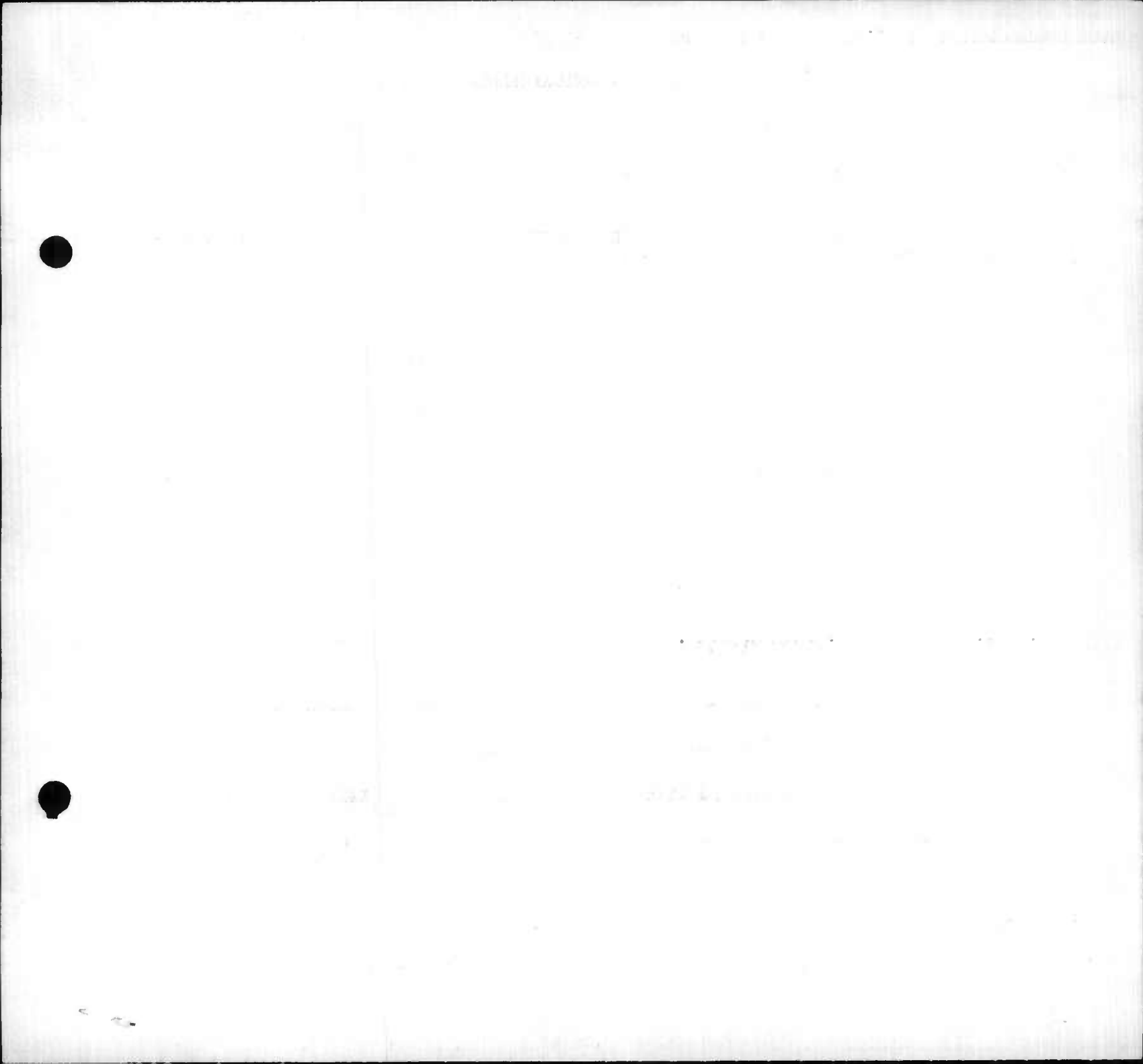




**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72 11931</u>	
BIRTH NO. <u>72 11931</u>		STATE OF MARYLAND - <u>DDMH</u>			
1. NAME OF DECEASED (Type or Print) <u>IDA FREIFELD</u>		2. DATE AND HOUR OF DEATH <u>12-13-1972</u> <u>3:20 P. M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2831</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>91</u> <u>LEVINDALE</u>		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>4120 NEWBERN AVENUE #21215</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/>	8. DATE OF BIRTH <u>1893 9/24/1893</u>	9. AGE (In years last birthday) <u>79</u>	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>	
13. FATHER'S NAME <u>JOSEPH YOSPE</u>		14. MOTHER'S MAIDEN NAME <u>RACHEL ?</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MRS. SYLVIA SOBER, 4 RUSSERN CT., APT. 2C #21215</u>	
18. <u>2507 I</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Pneumonia</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF:			
(C) <u>Diabetes Mellitus</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>No</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that <u>II</u> (this hospital) attended the deceased from <u>February 18</u> <u>19 65</u> to <u>December 13</u> <u>19 72</u> that <u>XX</u> (we) last saw the deceased alive on <u>December 13</u> <u>19 72</u> and that in <u>XX</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>XX</u> (We) (did) <u>not</u> view the body after death.					
23A. SIGNATURE <u>Soonchul Hong, M.D.</u>		23B. DATE SIGNED <u>12-13-1972</u>			
23C. PHYSICIAN'S NAME (Type) <u>SOON CHUL HONG, M.D.</u>		23D. ADDRESS <u>LEVINDALE</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24B. DATE <u>12/14/72</u>	24C. NAME OF CEMETERY or CREMATORY <u>HEBREW ORTHODOX MEMORIAL SOCIETY, BALTIMORE, MARYLAND</u>		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 18 1972</u>		25B. NAME OF REGISTRAR <u>Indy H. Winton</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</u>	



1  
B-620

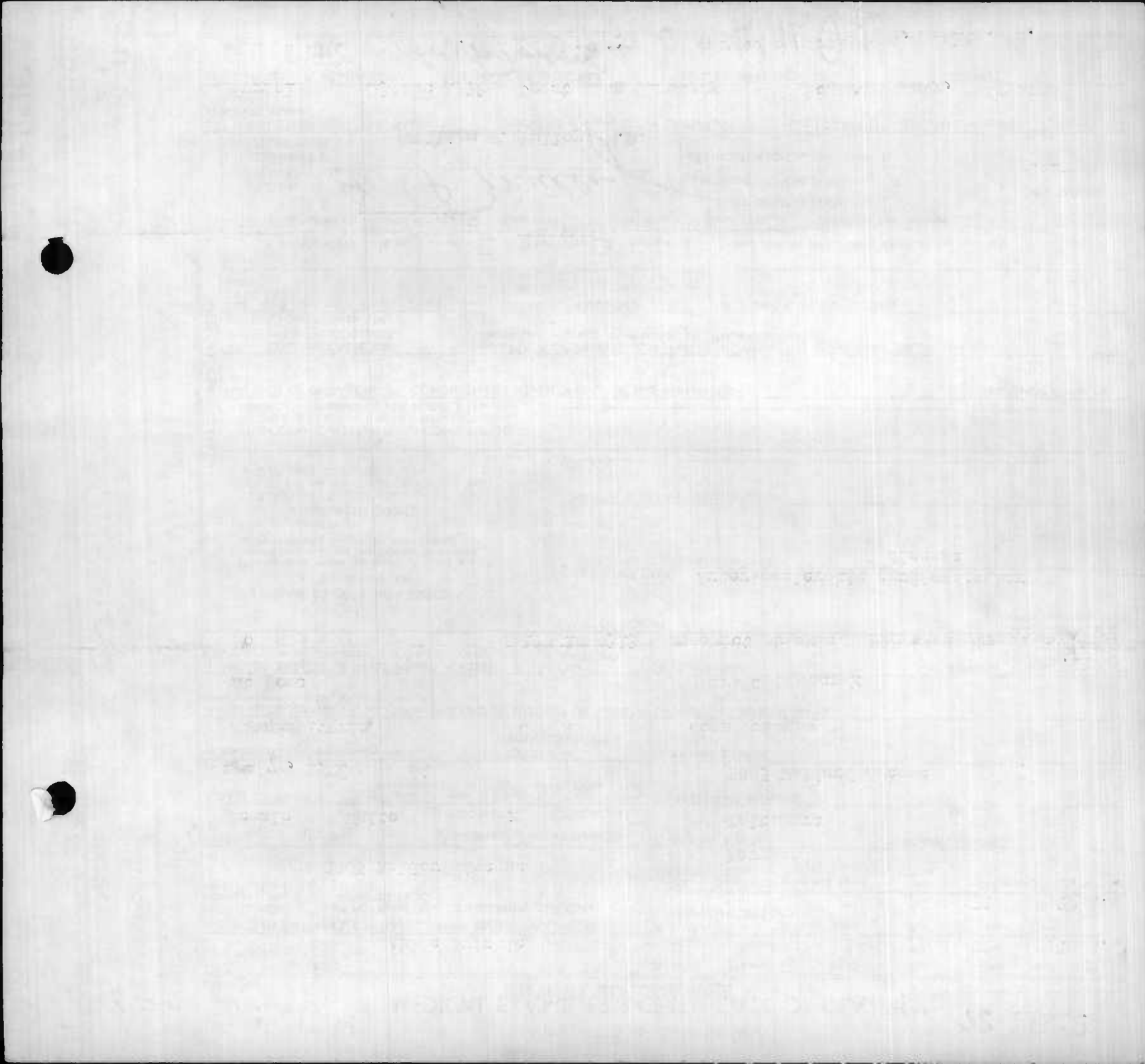
72 11932

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 11932

BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) Tillie Briskie		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 12 9 72 9:20 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 2805 Waldorf Avenue		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 9 72 9:20 A.M.	
6. SEX Female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission) A. STATE Maryland B. COUNTY 1513	
9. DATE OF BIRTH Sept 7, 1908		10. AGE (In years last birthday) 64	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Briskie		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home	
15. MOTHER'S MAIDEN NAME Martha Nowaczyk		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 173 18 0313		18. INFORMANT Benedict Briskie	
19. 412.4 CAUSE OF DEATH		ADDRESS NY 11219	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic cardiovascular disease			
(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C)			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <i>W P Mulloy</i> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) William P. Mulloy, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 12-9-72 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 13 Dec 1972	
24C. NAME OF CEMETERY or CREMATORY Crest Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Howard County, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 18 1972		25B. NAME OF REGISTRAR <i>Lindsey</i>	
25C. FUNERAL DIRECTOR Burgess Funeral Home, Balto. Md.		25D. ADDRESS <i>Walter J. Dennis</i>	



## CERTIFICATE OF DEATH

REG. NO.

72 11933

STATE OF MARYLAND-DEMO

BIRTH NO.

72 11933

1. NAME OF DECEASED

(Type or Print)

VANDENBERGE, JOHANNES DINGELUS

2. DATE AND HOUR OF DEATH

DECEMBER 14, 1972, 6:10 P.

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)40 ST AGNES HOSPITAL  
WILKENS & CATON AVENUES  
BALTIMORE, MARYLAND 21229

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

HOWARD

6300

C. CITY OR TOWN

COLUMBIA

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

10850 GREENMOUNTAIN CIRCLE - CONCORD HOUSE

5. SEX

MALE

6. RACE

CAUCASIAN

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

07 14 00

9. AGE (In years  
last birthday)

72

If Under 1 Yr.

Months: Days:

If Under 24 Hrs.

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

TRAFFIC CLERK

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

HOLLAND

12. CITIZEN OF WHAT COUNTRY?

HOLLAND

13. FATHER'S NAME

MARINUS VANDENBERGE

14. MOTHER'S MAIDEN NAME

JOANNA VAN BEEKUM

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL

SECURITY NO.

216547330

17. CATION AVES - BALTO, MD. 21229

ST AGNES HOSPITAL RECORDS - WILKENS &amp;

18. 379.31

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~(X)~~ (this hospital) attended the deceased from DECEMBER 13, 1972 to DECEMBER 14 1972,  
that ~~(X)~~ (we) lost saw the deceased alive on DECEMBER 14, 1972 and that in ~~(X)~~ (our) opinion death occurred on the date  
and hour and from the causes stated above. ~~(X)~~ (We) (did) ~~(X)~~ view the body after death.

23A. SIGNATURE

*M. Escalante*

M.D.

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

12/15/72

23C. PHYSICIAN'S  
NAME (Type)

AGATON H ESCALANCE, M.D.

AGATON H. ESCALANTE

23D. ADDRESS

ST AGNES HOSPITAL

ST. AGNES HOSPITAL

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

12/18/72

24C. NAME OF CEMETERY or CREMATORY

Meadowridge Cemetery

24D. LOCATION

(City, town, or county)

Dorsey, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

DEC 18 1972

25B. NAME OF REGISTRAR

*Sidney Johnson*

25C. FUNERAL DIRECTOR

Witke, 1630 Edmondson Avenue

ADDRESS

21228

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

SECTION H RESERVANCE, H. D.

SECTION H RESERVANCE, H. D.

XXXX

XX

DECEMBER 10, 1933

DECEMBER 12, 1933

DECEMBER 14, 1933

SECTION H RESERVANCE, H. D.  
SECTION H RESERVANCE, H. D.

SECTION H RESERVANCE, H. D.

SECTION H RESERVANCE, H. D.

SECTION H RESERVANCE, H. D.

SECTION H RESERVANCE, H. D.

SECTION H RESERVANCE, H. D.

SECTION H RESERVANCE, H. D.

SECTION H RESERVANCE, H. D.

SECTION H RESERVANCE, H. D.

SECTION H RESERVANCE, H. D.  
SECTION H RESERVANCE, H. D.  
SECTION H RESERVANCE, H. D.

SECTION H RESERVANCE, H. D.  
SECTION H RESERVANCE, H. D.  
SECTION H RESERVANCE, H. D.

SECTION H RESERVANCE, H. D.

SECTION H RESERVANCE, H. D.

SECTION H RESERVANCE, H. D.

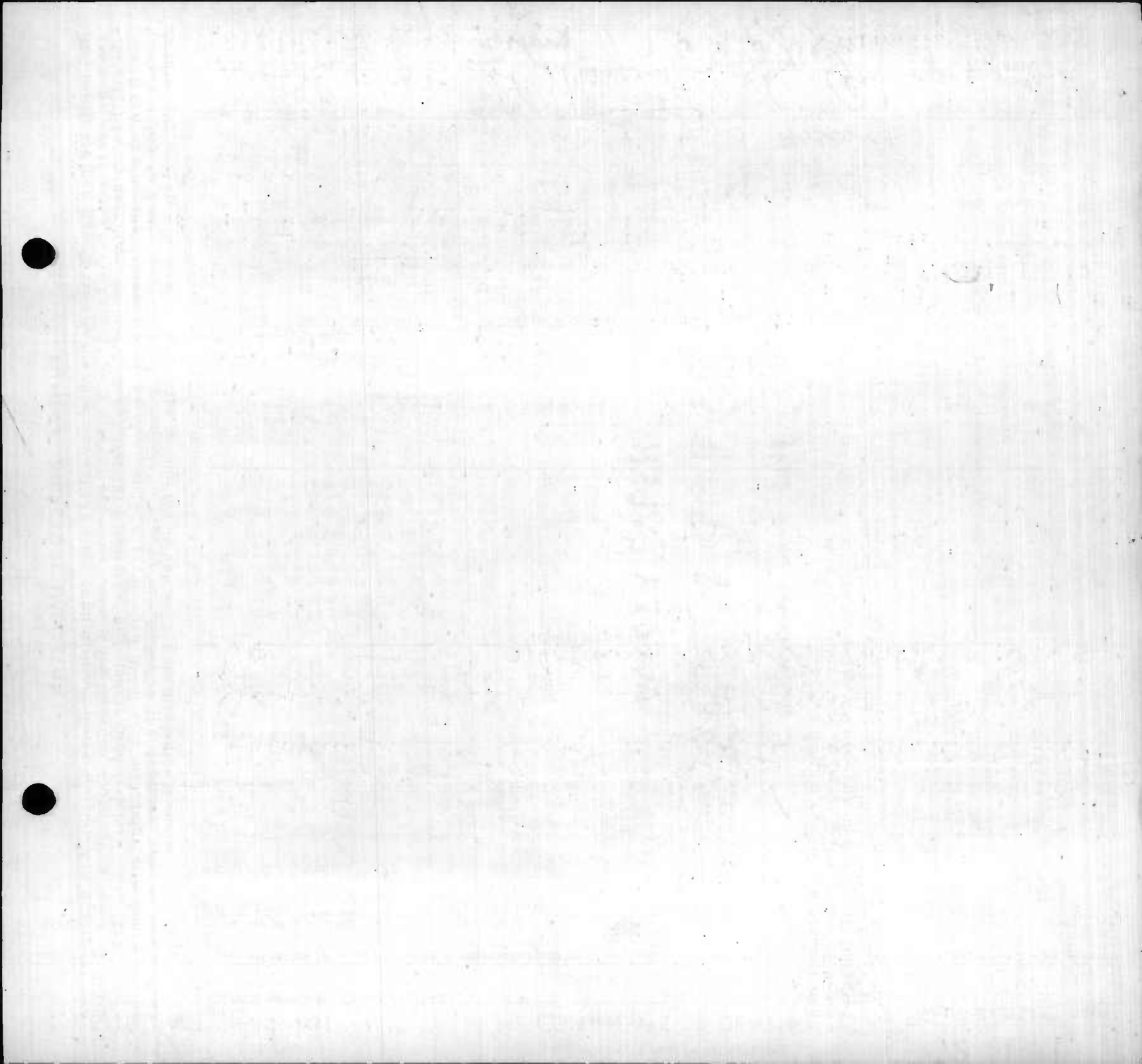


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-460 1		72 11934		BALTIMORE CITY HEALTH DEPARTMENT		72 11934	
72 11934		CERTIFICATE OF DEATH		REG. NO.		STATE OF MARYLAND-DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH					
Estelle C. Taylor		11 Dec. 1972 3 05 P.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Sinai Hospital				A. STATE B. COUNTY Md. A.A. 5200			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN Severna Park		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER 203 Springdale Ave			
5. SEX F	6. RACE C W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/23/07	9. AGE (In years last birthday) 65	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James S. Caffrey				14. MOTHER'S MAIDEN NAME Margaret Howell			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 2140506254		17. INFORMANT Gense E Taylor - Globe			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) Renal failure		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Polycystic renal disease		(B) DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C).....		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 17 NOV 19 72 to 11 Dec 19 72, that (I) (we) last saw the deceased alive on 11 Dec 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Karen M. Lichtenfeld MD				23B. DATE SIGNED 11 Dec. 1972		23C. PHYSICIAN'S NAME (Type) Karen M. Lichtenfeld MD	
23D. ADDRESS Sinai Hospital				23E. FUNERAL DIRECTOR Barbara Severna			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/14/72		24C. NAME OF CEMETERY or CREMATORY St Margaret Church		24D. LOCATION (City, town, or county) (State) Annapolis Md	
25A. DATE REC'D BY HEALTH DEPT. DEC 18 1972		25B. NAME OF REGISTRAR Sidney H. Hinton		25C. ADDRESS Barbara Severna		25D. ADDRESS md	





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-2401

72 11935

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

72 11935

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MARGARET Schieswohl

2. DATE AND HOUR OF DEATH  
12-10-72

5:15 a.m.

STATE OF MARYLAND-DEME

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

90 LONG GREEN NURSING HOME

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN  
BALTIMORE

D. INSIDE CITY LIMITS?  
YES ☒ NO ☐

E. STREET AND NUMBER  
4418 Belview Ave

5. SEX

Female

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☐  
WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

11-26-1890

9. AGE (in years last birthday)  
82

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

At Home

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

FRANCIS MOLZ

14. MOTHER'S MAIDEN NAME

HEINIGER

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

42-07-12314

17. INFORMANT

JAMES AWALT - 4418 Belview Ave

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

Pneumonia

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B) Cerebral A-S.

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

4 days

2 days

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

Rheumatoid arthritis

10 days

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

Pneumonia

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (the hospital) attended the deceased from 12/12/72 to 12/10/72 that (I) (we) last saw the deceased alive on 12/19/72 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.

23A. SIGNATURE

M. Freeman MD.

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

12/12/72

23C. PHYSICIAN'S NAME (Type)

M. Freeman JR

23D. ADDRESS

11 W. 24th St Baltimore

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

12-13-72

24C. NAME OF CEMETERY or CREMATORY

New Cathedral Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Md

25A. DATE REC'D BY HEALTH DEPT.

DEC 18 1972

25B. NAME OF REGISTRAR

Lindsey Houston

25C. FUNERAL DIRECTOR

ARMACOST Funeral Chapel - 4600 Liberty Hts Ave

ADDRESS

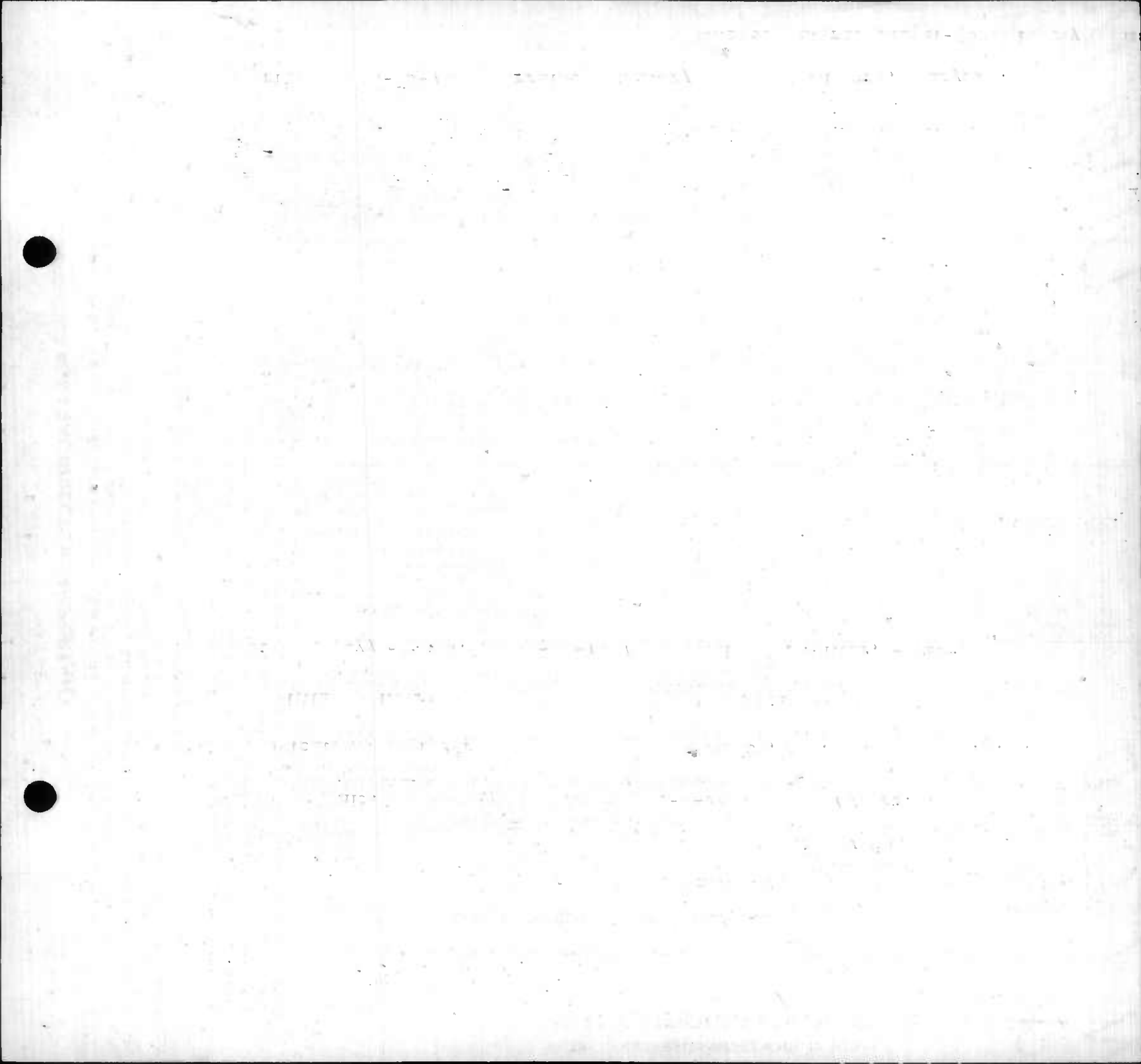
Blanket.

1001 it's a kind of blanket

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death was: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 11936</u>	
72 11936				STATE OF MARYLAND - DEPT.	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>PAUL G. Miller</u>			
2. DATE AND HOUR OF DEATH <u>12-10-72</u>		M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2802</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>00 5515 Fernpark Ave</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>5515 Fernpark Avenue</u>		5. SEX <u>Male</u> 6. RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>8-9-1894</u>		9. AGE (In years lost birthday) <u>78 Yrs.</u>		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
11. BIRTHPLACE (State or foreign country) <u>Granite, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>William Miller</u>		14. MOTHER'S MAIDEN NAME <u>Bodka</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes Navy - W.W.I</u>		16. SOCIAL SECURITY NO. <u>081-01-7607</u>		17. INFORMANT <u>Adelaide M. Miller, - Same</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Coronary Occlusion</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Marked Senility (Arteriosclerosis)</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Hernia</u> (C) DUE TO, OR AS A CONSEQUENCE OF: <u>Degenerative Heart Disease</u>			
19. DATE OF OPERATION <u>12-10-72</u>		20. AUTOPSY? (Yes or No) <u>No</u>		21. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>No</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>12-9</u> 19 <u>72</u> to <u>12-10-72</u> and that (I) (we) last saw the deceased alive on <u>12-10-72</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23. SIGNATURE <u>Thomas E. Abbott</u>			
24. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		25. DATE <u>12-13-72</u>		26. NAME OF CEMETERY OR CREMATORY <u>Lorraine Cemetery</u>	
27. LOCATION <u>Baltimore, Maryland</u>		28. DATE REC'D BY HEALTH DEPT. <u>DEC 18 1972</u>			
29. NAME OF REGISTRAR <u>Adelaide M. Miller</u>		30. FUNERAL DIRECTOR <u>Macost Funeral Chapel-4600 Liberty Hight</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 11937</b>	
BIRTH NO. <b>72 11937</b>				STATE OF MARYLAND-DEMC-	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
<b>Artelia Douglas</b>			<b>12/11/72</b>		<b>2:20 a. M.</b>
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>33 The Johns Hopkins Hospital</b>			A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
E. STREET AND NUMBER <b>5923 Leewood Avenue</b>					
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/1/00</b>	9. AGE (In years last birthday) <b>72</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Thomas Adams</b>			14. MOTHER'S MAIDEN NAME <b>Alice Brown</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
18. <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>Respiratory arrest</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Probable pulmonary emboli</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>45 minutes</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(B) DUE TO, OR AS A CONSEQUENCE OF: (C) Congestive heart failure, pneumonia, ASCVD</b>					<b>6 hrs.</b> <b>weeks to several years</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>10</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>December 1</b> 19 <b>72</b> to <b>present</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>December 10</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Edward James Busick Jr.</b>				23B. DATE SIGNED <b>12/11/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Edward James Busick M.D.</b>				23D. ADDRESS <b>The Johns Hopkins Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-14-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Memorial Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 18 1972</b>		25B. NAME OF REGISTRAR <b>Sidney B. Horton</b>		25C. FUNERAL DIRECTOR <b>Edith L. Snowden</b>	
246 N. Wash. St. <b>Pockville, Md. 20850</b>					

W. H. K. S. 1917

TO THE HONORABLE SECRETARY OF THE ARMY

WASHINGTON, D. C.

SIR: I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the matter of the proposed purchase of the land at the mouth of the River, and in reply to inform you that the same has been referred to the proper authorities for their consideration.

I am, Sir, very respectfully,  
Yours very truly,  
W. H. K. S.

Very truly,  
W. H. K. S.

Very truly,  
W. H. K. S.

Very truly,  
W. H. K. S.

Very truly,  
W. H. K. S.



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
72 11938				72 11938	
CERTIFICATE OF DEATH					
BIRTH NO.		STATE OF MARYLAND-DEMD			
1. NAME OF DECEASED (Type or Print) <b>MELISSARATOS, STELLA</b>		2. DATE AND HOUR OF DEATH <b>12-12-1972 1.35 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2643</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSP.</b> <b>44</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>3629 Elmora Avenue</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>05-10-1894</b>	9. AGE (In years lost birthday) <b>78</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>ROMANIA</b>	
13. FATHER'S NAME <b>Panajiotis Melissaratos</b>		12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES OF AMERICA</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-38-4164A</b>		17. INFORMANT <b>Peter Melissaratos</b> <b>3629 Elmora Ave., Baltimore Md.</b>	
18. <b>7/2/74</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>RIGHT LOWER LOBE PNEUM</b> (B) <b>C.V.A. (OLD)</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>CHRONIC CONGESTIVE HEART FAILURE</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>ASCVD.</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12-12-72 10.30 AM</b> to <b>12-12-72 11</b> , that (I) (we) last saw the deceased alive on <b>12/12/72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>H WENDORFF</b>				23B. DATE SIGNED <b>12/12/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>HERMANN WENDORFF</b>				23D. ADDRESS <b>UNION MEMORIAL HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-15-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Oak Lawn Cemetery</b>	
				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 18 1972</b>		25B. NAME OF REGISTRAR <b>Dorothy M. ...</b>		25C. FUNERAL DIRECTOR <b>Nicholas T. Matthews</b> <b>6302 Eastern Ave., Baltimore, Md.</b>	

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

HERBARIUM OF THE UNITED STATES DEPARTMENT OF AGRICULTURE  
WASHINGTON, D. C.

PLANT INDUSTRY  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

PLANT INDUSTRY  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

PLANT INDUSTRY  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

PLANT INDUSTRY  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

PLANT INDUSTRY  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

PLANT INDUSTRY  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

PLANT INDUSTRY  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

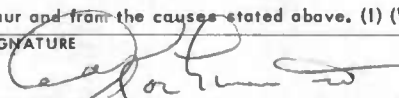
PLANT INDUSTRY  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

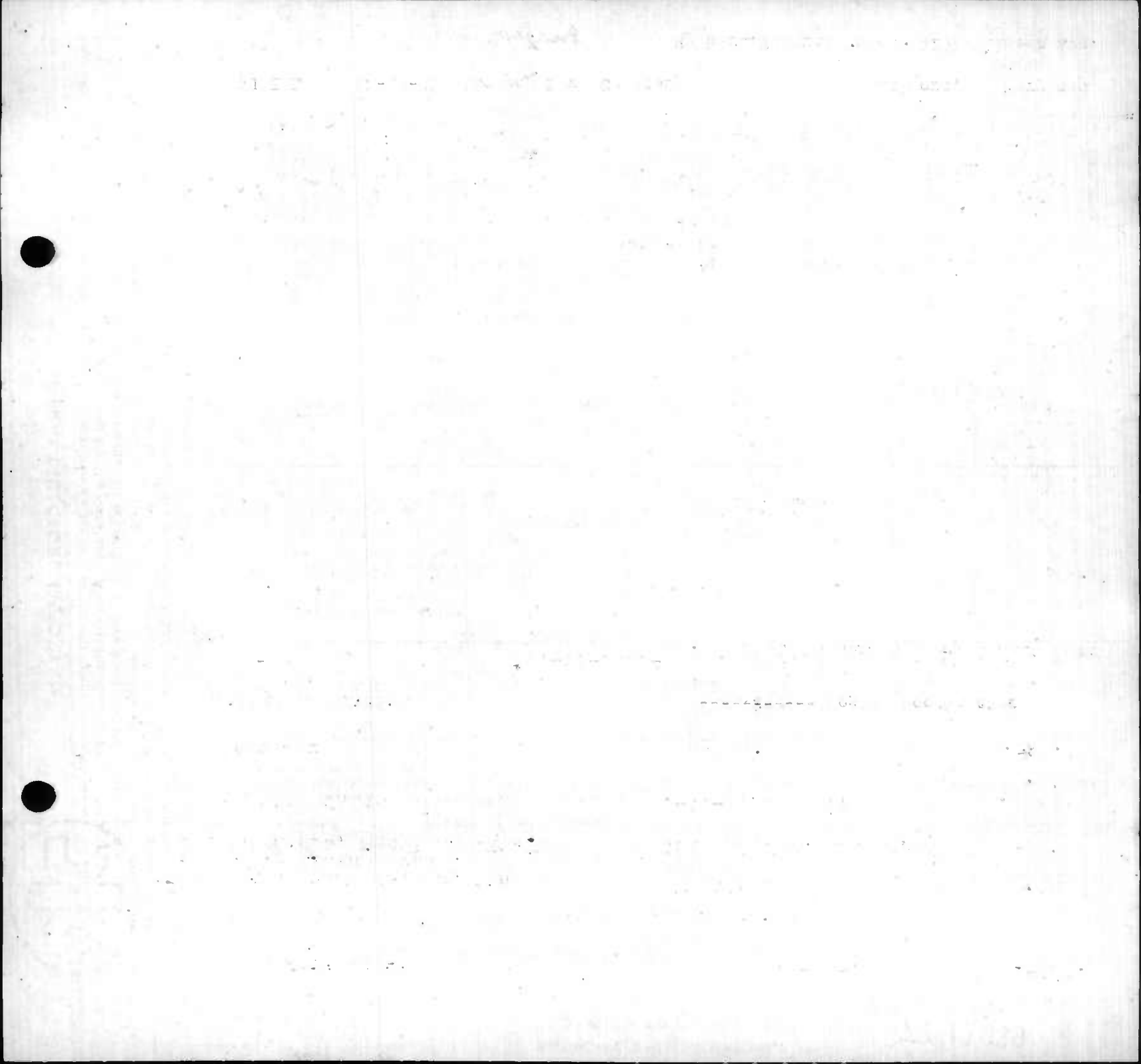
PLANT INDUSTRY  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

PLANT INDUSTRY  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>72 11939</b>	
72 11939		STATE OF MARYLAND - <del>DUMF</del>	
BIRTH NO.		DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Amelia Trust</b>		12-12-72   6-45P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <b>Caton Manor Nursing Center 3330 Wilkens Avenue Baltimore, Maryland 21229</b>		A. STATE <b>Maryland</b> B. COUNTY <b>BALTO</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>3529 Milford Mill Road</b>	
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-21-1895</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Christian Scheidt</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>-</b>		16. SOCIAL SECURITY NO. <b>217-12-5438</b>	
17. INFORMANT <b>Mr. Christian Trust</b>		ADDRESS <b>1002 Elm Road</b>	
18. <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Heart Block</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Heart Block</b> (B) <b>Antecedent Causes</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Antecedent Causes</b> (C) _____	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Nov. 6, 1972</b> to <b>Dec. 12, 1972</b> , that (I) (we) last saw the deceased alive on <b>Dec. 11, 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE 		23B. DATE SIGNED <b>12-13-72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. A. A. Kochman</b>		23D. ADDRESS <b>14.0 DEGREE 7945 Stevenson Rd. Baltimore 21208</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12-16-72</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 18 1972</b>		25B. NAME OF REGISTRAR <b>Didney W. H. H. H.</b>	
25C. FUNERAL DIRECTOR <b>Hubbard Funeral Home</b>		ADDRESS <b>4107 Wilkens Ave.</b>	



W-436 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO. 72 11940

BIRTH NO. 72 11940

1. NAME OF DECEASED  
(Type or Print)

Charles Curtis Walter

2. DATE AND HOUR OF DEATH  
Dec. 14, 1972

3:25 A. M.

STATE OF MARYLAND-DEMH

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)US Public Health Service Hospital  
3100 Wyman Parkway4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)  
A. STATE Pa.C. CITY OR TOWN  
Chester Springs

D. INSIDE CITY LIMITS?

YES ☐NO ☐E. STREET AND NUMBER  
Old Mill Farm5. SEX  
M

6. RACE

Caucasian

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

5/26/04

9. AGE (in years  
last birthday)

68

10. Under 1 Yr.  
Months Days11. Under 24 Hrs.  
Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Security Spec

10B. KIND OF BUSINESS OR INDUSTRY

Stock Broker

11. BIRTHPLACE (State or foreign country)

NY

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Thomas C. Walter

14. MOTHER'S MAIDEN NAME

Caroline Versfelt

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

056-01-7137

17. INFORMANT

ADDRESS

Records- US PHS Hospital, Balto, Md.

18. 20411

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

Sepsis

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH  
Days(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Pneumonia &amp; peritonitis

2 weeks

ANTECEDENT CAUSES

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Chronic lymphocytic leukemia

Years

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

yes

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Nov. 3, 1972 to Dec. 14, 1972  
that (I) (we) last saw the deceased alive on Dec. 14, 1972 and that (I) (my) (our) opinion death occurred on the date  
and hour and from the causes stated above; (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

12/14/72

23C. PHYSICIAN'S  
NAME (Type)

Robert H. Kirschner, MD

23D. ADDRESS

US PHS Hospital, Balto, Md. 21211

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

CREMATION

12-18-1972

DELAWARE VALLEY CEMETERY

Southampton Bucks Co. Pa.

25A. DATE REC'D BY HEALTH DEPT.

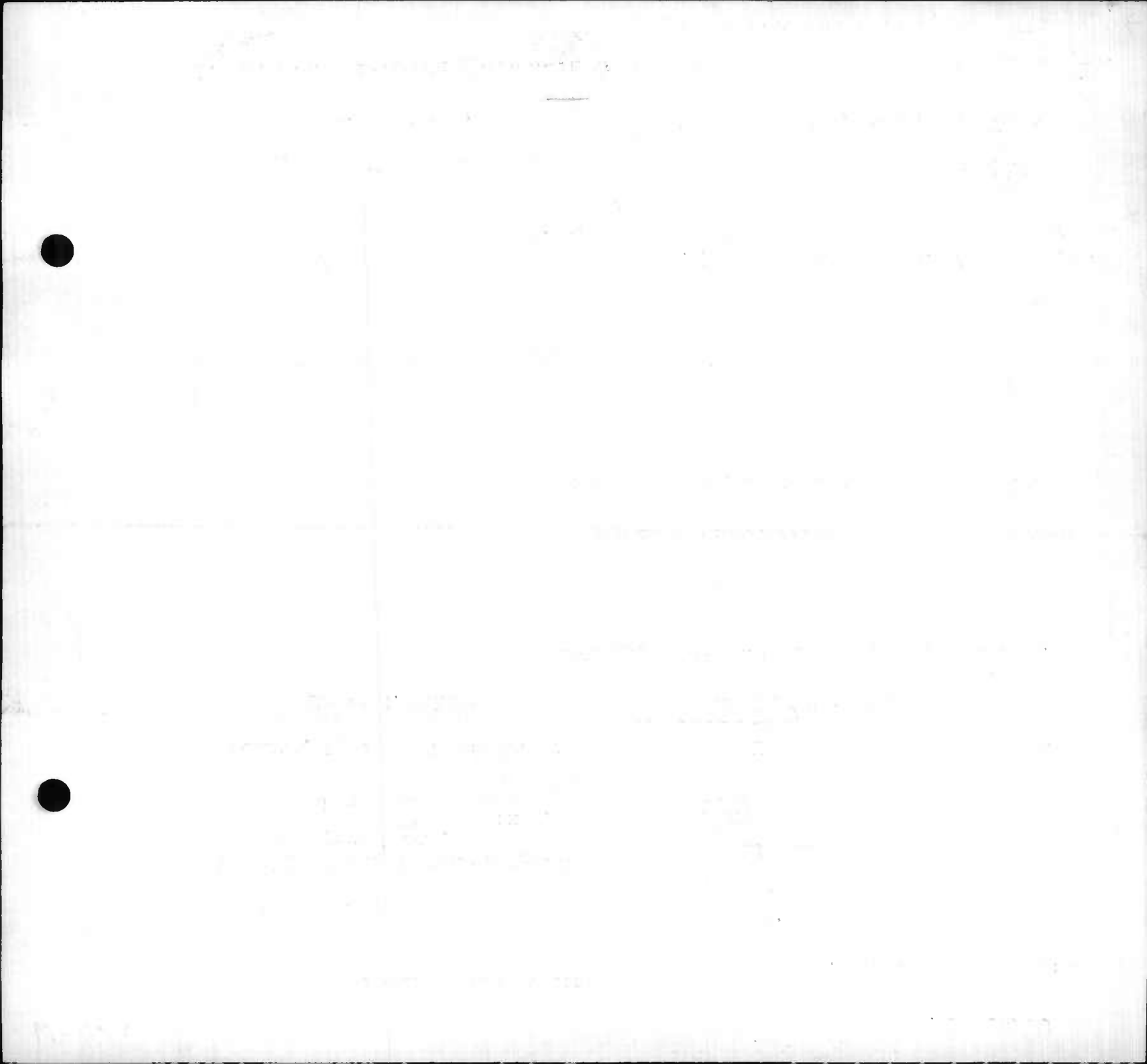
DEC 18 1972

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

Wm. Cook-Brooks Towson, Inc. Towson, Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 72 11941				CITY HEALTH DEPARTMENT		REG. NO. 72 11941	
F-623				STATE OF MARYLAND-DHMH		11:20 A M.	
1. NAME OF DECEASED (Type or Print) <u>Forrest, Wilbur C.</u>				2. DATE AND HOUR OF DEATH <u>12-13-1972</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>902</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Long Green Nursing Home</u> <u>115 E. Melrose Ave.</u> <u>Balt. Md. 21212</u>				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>M</u> 6. RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>5/20/1896</u> 9. AGE (In years last birthday) <u>76 yrs</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>William E. Forrest</u>				14. MOTHER'S MAIDEN NAME <u>Lena Myer</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>WWI</u>				16. SOCIAL SECURITY NO. <u>216-69-9360</u>		17. INFORMANT <u>JEAN F. CLARK</u>	
18. <u>412.41</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Bronchopneumonia</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Arteriosclerotic condition</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) _____	
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>January 1969</u> to <u>December 13, 1972</u> , that (I) (we) last saw the deceased alive on <u>December 13, 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>A. Allan Smith</u>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>12/13/72</u>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>12-16-1972</u>		24C. NAME OF CEMETERY <u>Moreland Memorial</u>		24D. LOCATION (City, town, or county) (State) <u>Parkville Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 18 1972</u>		25B. NAME OF REGISTRAR <u>James H. Heston</u>		25C. FUNERAL DIRECTOR <u>Don Cook-Brooks</u>		25D. ADDRESS <u>Towson, Md.</u>	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

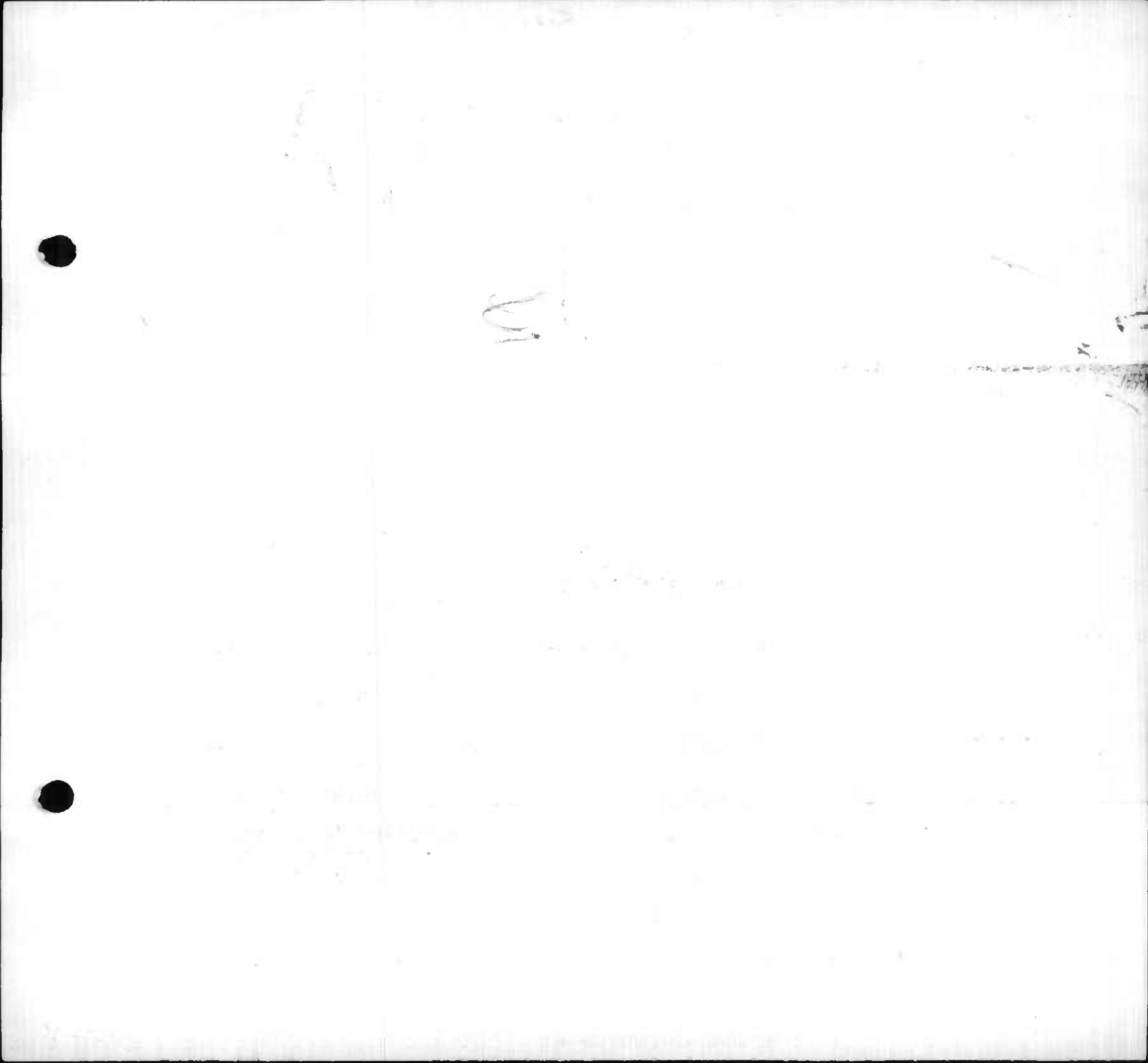
N-3501

72 11942

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

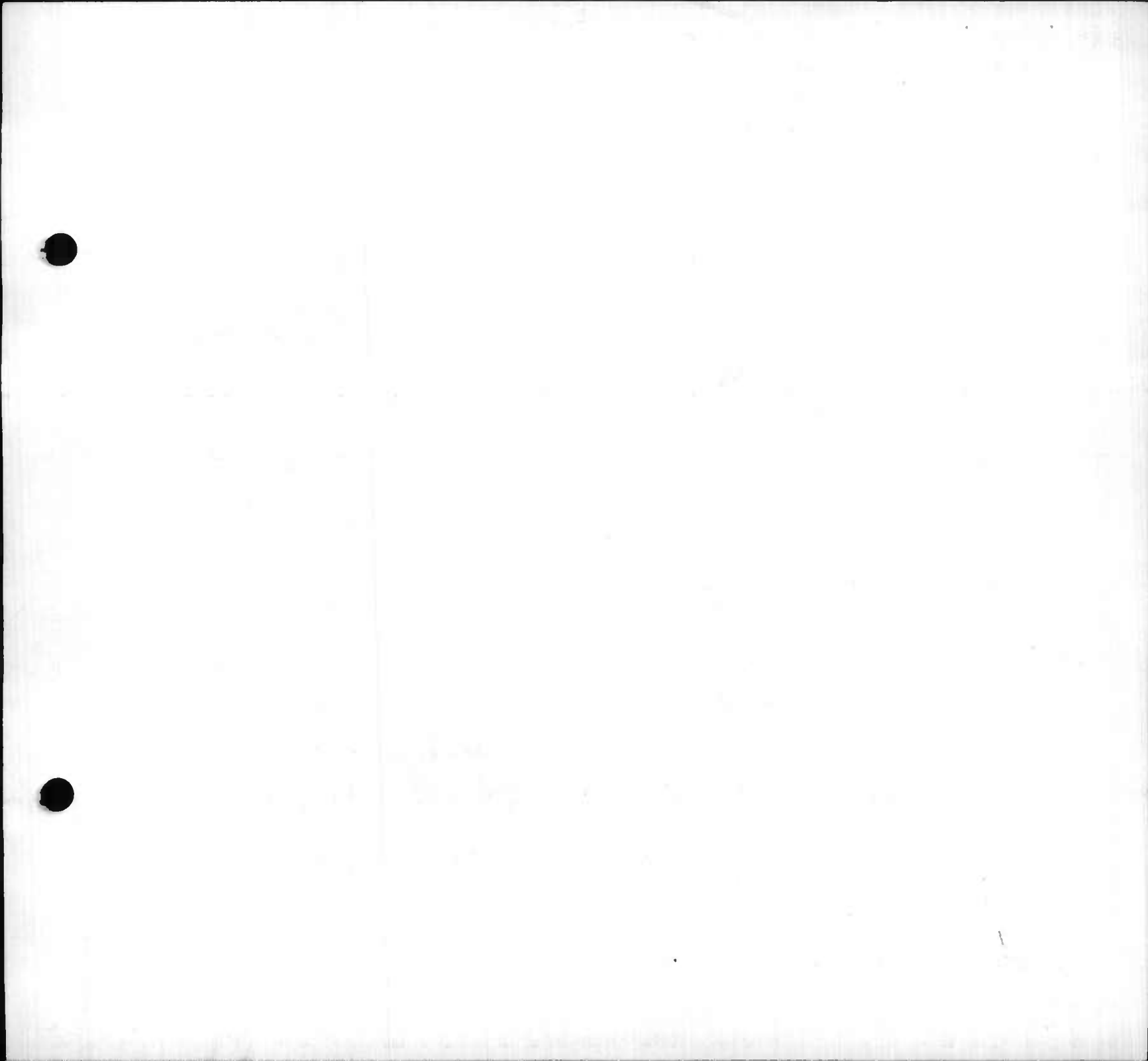
REG. NO. 72 11942  
STATE OF MARYLAND-DHMH

BIRTH NO. 72 11942		2. DATE AND HOUR OF DEATH December 13, 1972 3:05 p.m.	
1. NAME OF DECEASED (Type or Print) E. Irene Newton		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1509	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Caton Manor Nursing Home 3330 Wilkens Ave. Baltimore, Maryland		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3903 Forest Park Ave.	
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/5/90
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) No Teacher		10B. KIND OF BUSINESS OR INDUSTRY Public School	9. AGE (In years last birthday) 82
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ? Newton		14. MOTHER'S MAIDEN NAME Elvira ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No --		16. SOCIAL SECURITY NO. 220-44-8865	17. INFORMANT ADDRESS Caton Manor Nursing Home Records
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Bronchopneumonia</u> (B) <u>Advanced A.D.P.V.D.</u> (C) _____	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 mo 1035			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 5-27-1972 to 12-13-1972 that (I) (we) last saw the deceased alive on 12-13-1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Wilmer K. Gallagher, Sr.</u>		23B. DATE SIGNED 12/14/72	
23C. PHYSICIAN'S NAME (Type) Wilmer K. Gallagher, Sr. M.D.		23D. ADDRESS 6209 Frederick Avenue Baltimore Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/16/72	
24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 18 1972		25B. NAME OF REGISTRAR <u>Indy...</u>	
25C. FUNERAL DIRECTOR Eugenia K. Seitz		ADDRESS 21212 Seitz Funeral Home 5209 York Rd. Balto Md	



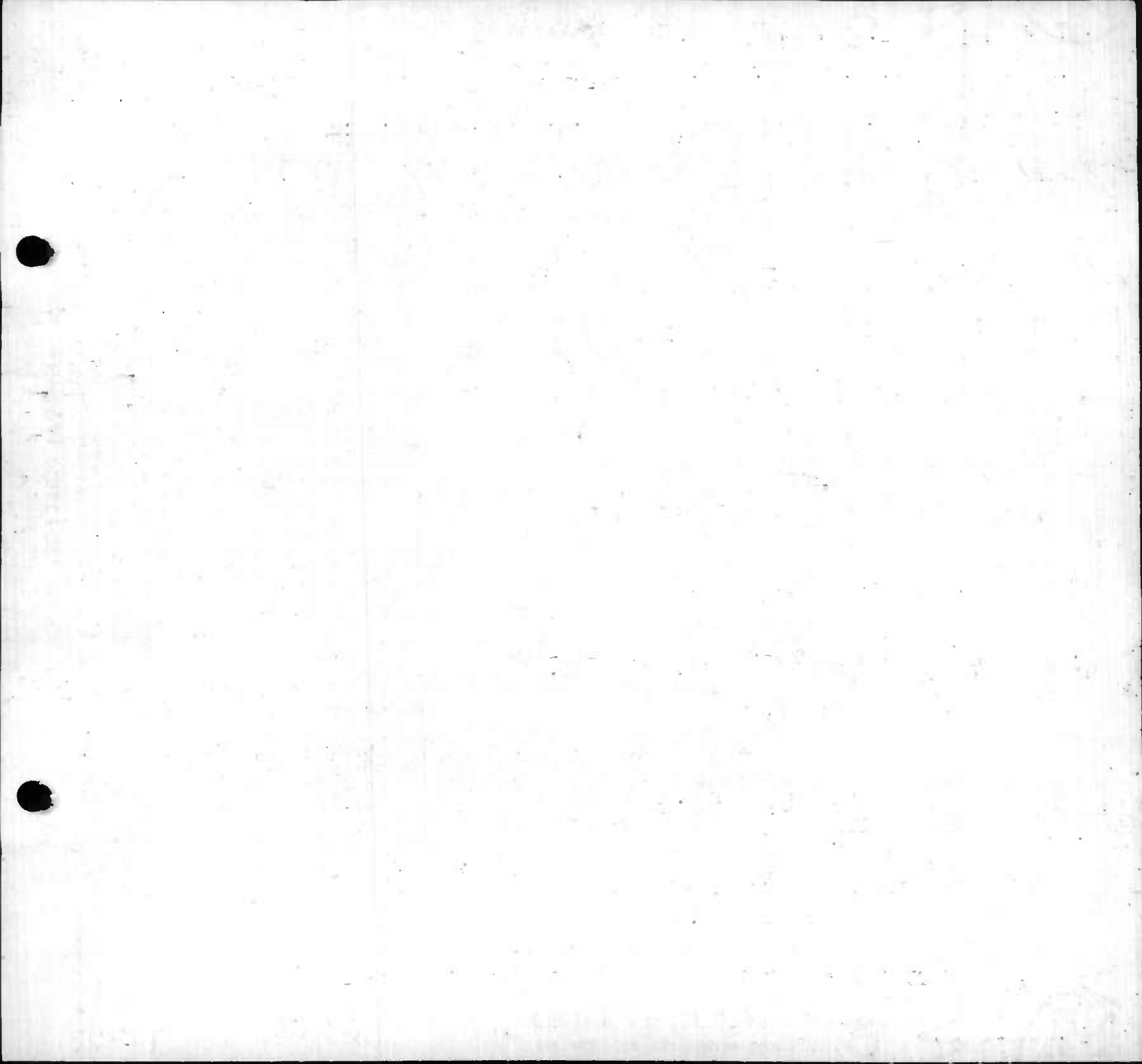
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
Rollins Marie W.		12.13.1972 10:55 p.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY	
South Baltimore General Hospital		Maryland AA 5200	
5. SEX F		6. RACE W	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-15-95	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (in years last birthday) 77	
Retired Saleswoman		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME		12. CITIZEN OF WHAT COUNTRY?	
Unknown		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
NO		2-16-14-3134-A	
17. INFORMANT		ADDRESS	
Kendall Rollins (Son)		619 Wood St. 21225	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO, OR AS A CONSEQUENCE OF:	
Chronic renal failure		(B) Atherosclerotic Cardiovascular disease	
DUE TO, OR AS A CONSEQUENCE OF:		(C)	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		20A. AUTOPSY? (Yes or No)	
19A. DATE OF OPERATION		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
White At <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 12.13.1972 to 12.13.1972 that (we) last saw the deceased alive on 12.13.1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE		23B. DATE SIGNED	
Uhon Ro. Lee		12.13.1972	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
Uhon Ro. Lee		South Baltimore General Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
Burial		12/16/72	
24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Cedar Hill		Brooklyn Park Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
DEC 18 1972		Sidney [Signature]	
25C. FUNERAL DIRECTOR		ADDRESS	
Mc Callie		237 Patapsco Ave. Balto. 21225	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
72 11944				72 11944	
CERTIFICATE OF DEATH				STATE OF MARYLAND - DHMH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Edward J. Jeunette		December 11, 1972 11:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
00 3511 Falls Rd.			Md. 1306		
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH		9. AGE (In years lost in day)		10. CITIZEN OF WHAT COUNTRY?	
Apr. 29, 1890		82		USA	
11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Ohio			USA		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
John Jeunette			Collignon		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
Yes WWI			213-01-0263		
17. INFORMANT			ADDRESS		
Marie C. Jeunette			3511 Falls Rd.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTecedent CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from Dec 7 1967 to 11 Dec 72, that (I) (we) last saw the deceased alive on Dec 7 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Wm. G. Helfrich, M.D.				12-12-72	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Wm. G. Helfrich, M.D.		5006 Roland Ave.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		12/15/72		Dulaney Valley Mem. Gard., Balto. Co., Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
DEC 18 1972		Sidney H. Hoston		Alan Spitz, Jr. - 3818 Roland Ave.	

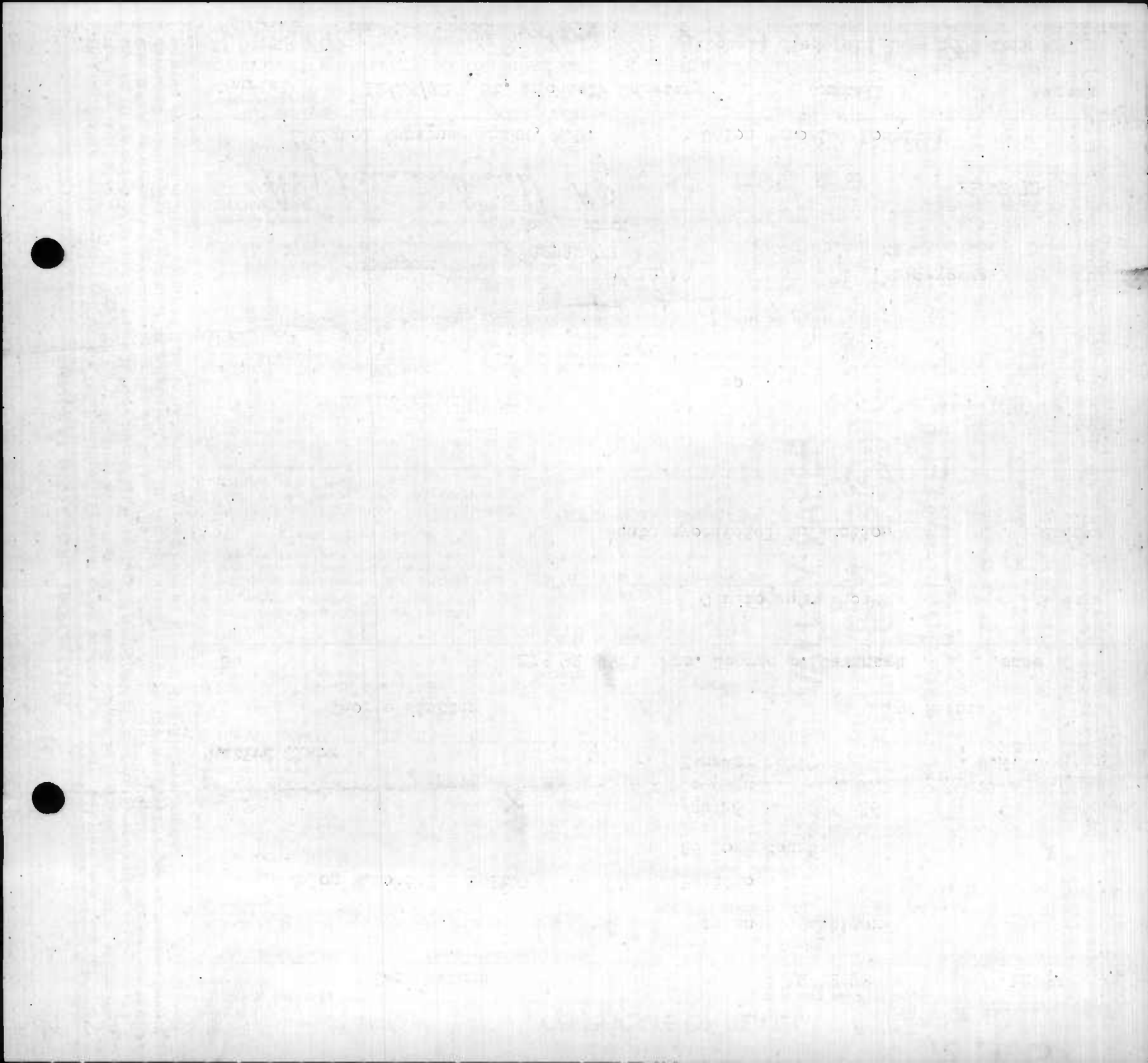




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 11945	
CERTIFICATE OF DEATH				STATE OF MARYLAND-DEPT	
BIRTH NO. 72 11945		1. NAME OF DECEASED (Type or Print) Lena Waters		2. DATE AND HOUR OF DEATH 12/12/72 12:50 p.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 Union Memorial Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 25 York Court		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/24/86	9. AGE (In years last birthday) 86	10. Under 1 Yr. Months: Days: 10. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Kansas	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME George Winkler		
14. MOTHER'S MAIDEN NAME Anna Karnes			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY N. 215 32 14981		17. INFORMANT Mrs. George B. Cavanagh		ADDRESS same	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiogenic shock (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute myocardial infarction (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 2 days	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from 12/10/72 to 12/12/72, that (I) (we) lost saw the deceased alive on 12/12/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Miguel Karacuschansky, M.D.				23B. DATE SIGNED 12/12/72	
23C. PHYSICIAN'S NAME (Type) Miguel Karacuschansky, M.D.				23D. ADDRESS Union Memorial Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/15/72		24C. NAME OF CEMETERY OR CREMATORY St. Michaels Cemetery	
24D. LOCATION (City, town, or county) Axtell		(State) Kansas			
25A. DATE REC'D BY HEALTH DEPT. DEC 18 1972		25B. NAME OF REGISTRAR Sidney H. ...		25C. FUNERAL DIRECTOR Mitchell Wiedefeld Home 6500 York Rd.	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 11946</b>	
BIRTH NO. <b>72 11946</b>				STATE OF MARYLAND - DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		M.	
<b>MARGARET WALEGA</b>		<b>12-12-72</b>		<b>2:10 P</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>THE JOHNS HOPKINS HOSPITAL</b> <b>33</b>			A. STATE <b>MARYLAND</b> B. COUNTY <b>2653</b>		
(If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <b>1645 FREEDOM WAY NORTH</b>					
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-18-19</b>	9. AGE (In years last birthday) <b>53</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>DOMINIC MARINO</b>			14. MOTHER'S MAIDEN NAME <b>Elvira Lucarto</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>215039248</b>		17. INFORMANT <b>Michael Walega</b>	
18. <b>422.21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(A) IMMEDIATE CAUSE <b>Cerebral ischaemic arrest</b> DUE TO, OR AS A CONSEQUENCE OF:					
(B) <b>Cerebral ischaemic damage</b> DUE TO, OR AS A CONSEQUENCE OF:					
(C) <b>Cerebral ischaemic arrest of unknown origin</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <b>6</b> (this hospital) attended the deceased from <b>12/8</b> 19 <b>72</b> to <b>12/12</b> 19 <b>72</b> , that <b>4</b> (we) lost saw the deceased alive on <b>12/12</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <b>4</b> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Heldo Park Wray</b>				23B. DATE SIGNED <b>12/12/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>HELDON PARK WRAY M.D.</b>				23D. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/15/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Cross Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>A.A.Co. Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 18 1972</b>		25B. NAME OF REGISTRAR <b>Sidney J. Heston</b>		25C. FUNERAL DIRECTOR <b>George J. Conce</b>	
25D. ADDRESS <b>4001 Ritchie Highway</b>					

MI 10

MI 5

MI 10

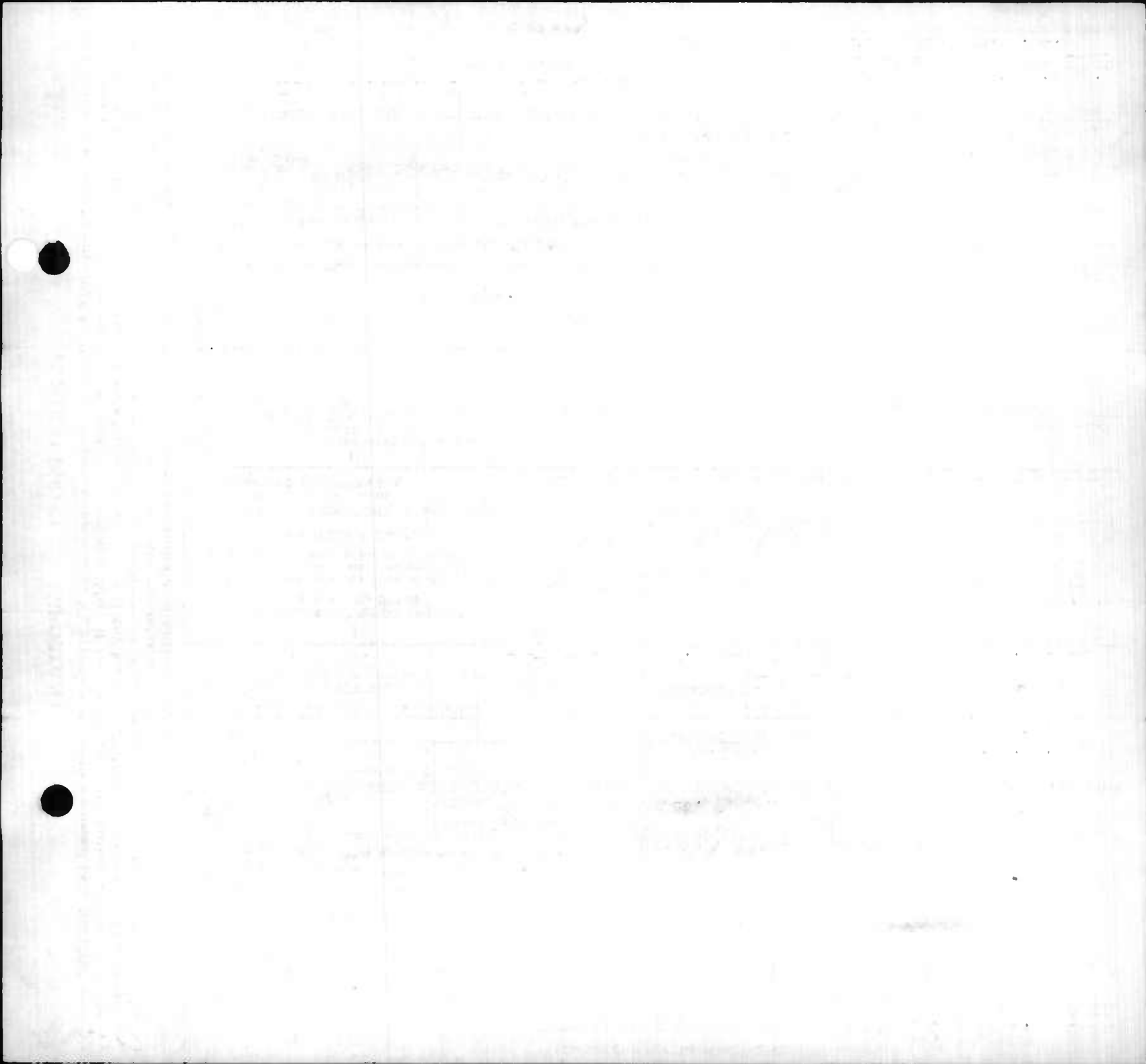
MI 10

MI 10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 72 11947				CITY HEALTH DEPARTMENT		REG. NO. 72 11947	
CERTIFICATE OF DEATH				STATE OF MARYLAND-DHMH			
1. NAME OF DECEASED (Type or Print) <u>Mary Morris</u>				2. DATE AND HOUR OF DEATH <u>12/16/72 11:30 PM</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2831</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Sinai Hospital</u> <u>Belvedere Green Spring Avenue</u> <u>Baltimore, Maryland 21133</u>				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>4109 Hayward Avenue</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 9, 1910</u>		9. AGE (In years last birthday) <u>62</u>	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>FREDERICK ZERRLAUT</u>				14. MOTHER'S MAIDEN NAME <u>EUNETTA (?)</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> <u>NONE</u>		16. SOCIAL SECURITY NO. <u>212-70-6273</u>		17. INFORMANT <u>Mr. Chester Morris</u>		ADDRESS <u>4109 Hayward Avenue</u> <u>Baltimore, Md. 21215</u>	
18. <u>753.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Renal Failure</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Polycystic Kidney Disease</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
19. DATE OF OPERATION <u>0</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from <u>11/26</u> <u>1972</u> to <u>12/12</u> <u>1972</u> that (I) (we) last saw the deceased alive on <u>12/12</u> <u>1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Robert Krapnick M.D.</u>				23B. DATE SIGNED <u>12/13/72</u>		23C. PHYSICIAN'S NAME (Type) <u>Randolph</u>	
23D. ADDRESS <u>9008 Meadowlark Rd.</u>				23E. CITY, TOWN, OR COUNTY <u>BALTO. CO., MD.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>12/16/1972</u>		24C. NAME OF CEMETERY OR CREMATORY <u>WOODLAWN CEMETERY</u>		24D. LOCATION <u>WOODLAWN BALTO. CO., MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 18 1972</u>		25B. NAME OF REGISTRAR <u>Lindsey</u>		25C. FUNERAL DIRECTOR <u>Loring Byers</u>		ADDRESS <u>8728 Liberty Road</u> <u>21133</u>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 11948	
BIRTH NO. 72 11948				STATE OF MARYLAND-DEMI	
1. NAME OF DECEASED (Type or Print) RYLAND BANKS			2. DATE AND HOUR OF DEATH 12/11/72 240 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 THE JOHNS HOPKINS HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY HARFORD		
5. SEX MALE 6. RACE NEGRO 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 8-12-95 9. AGE (In years last birthday) 77 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 11. BIRTHPLACE (State or foreign country) Aberdeen, Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME GEORGE BANKS			14. MOTHER'S MAIDEN NAME Sallie McGaw (Deceased)		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 220 05 8100 17. INFORMANT William H. Banks, Havre de Grace, Md.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 1/62.1 I CAUSE OF DEATH RESPIRATORY, CARDIAC ARREST 10 min (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) HEMOPTYSIS AND ASPIRATION 10 min DUE TO, OR AS A CONSEQUENCE OF: (C) SQUAMOUS CELL CARCINOMA OF LUNG 2 year			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (nately medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/11 19 72 to 12/11 19 72, that (I) (we) last saw the deceased alive on 12/11 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John B. Welch MD, PhD DEGREE				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) JOHN B. WELCH MD, PhD DEGREE				23D. ADDRESS TOLHNS HOPKINS HOSP, BALTO. MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec. 16, 1972		24C. NAME OF CEMETERY OR CREMATORY Asbury Methodist Cemetery Churchville, Harford Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 18 1972		25B. NAME OF REGISTRAR Sidney W. ...		25C. FUNERAL DIRECTOR Tarring Funeral Home 333 S. Parke St., Aberdeen, Maryland.	



515

x

S-6361

72 11949

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 72 11949

STATE OF MARYLAND-DEPT

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MARTIN J. SCHRADER

2. DATE AND HOUR OF DEATH

12/15/72

6 30 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

CHURCH HOME + HOSPITAL  
5100 N. BROADWAY  
BALTIMORE MARYLAND 21231

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE B. COUNTY

MD.

103

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

506 S. MONFORD AVE. 21224

5. SEX

M

6. RACE

W

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

OCT. 20-1906 66

9. AGE (In years last birthday)

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

CLERK

10B. KIND OF BUSINESS OR INDUSTRY

BOWIE-SMITH LUMBER CO.

MD.

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

AMERICA

13. FATHER'S NAME

MARTIN SCHRADER SR.

14. MOTHER'S MAIDEN NAME

JOHANNA RYDZINSKI

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO / / /

16. SOCIAL SECURITY NO.

212-03-2216

17. INFORMANT

THERESA SCHRADER 506 S. MONFORD AVE

ADDRESS

18. 412.21

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:

HYPERT. C V D

10 y

(B) DUE TO, OR AS A CONSEQUENCE OF:

CHRONIC INGESTION OF F

2 y

(C) \_\_\_\_\_

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2/1 1972 to 12/14 1972, that (I) (we) last saw the deceased alive on 12/14 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

S C Feldman

Attending Phys. ☒Med. Director ☐Staff Phys. ☐

23B. DATE SIGNED

12/16/72

23C. PHYSICIAN'S NAME (Type)

S C Feldman

23D. ADDRESS

1440 E. Bulte

12

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

12/19/72

24C. NAME OF CEMETERY OR CREMATORY

ST. STANISLAUS CEMETERY BALTIMORE MARYLAND

24D. LOCATION (City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT.

DEC 18 1972

25B. NAME OF REGISTRAR

Sidney [illegible]

25C. FUNERAL DIRECTOR

M. F. SADOWSKI &amp; SONS 1808 EASTERN AVE.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

OUTSTANDING DEBITORS LIST AT 1/1/1948  
JANUARY 1948

AMOUNT DUE TO COMPANY  
DATE PAID  
NAME OF DEBTOR  
ADDRESS  
CITY  
STATE  
ZIP

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 11950
CERTIFICATE OF DEATH				72 11950
BIRTH NO.		REG. NO.		STATE OF MARYLAND-DEMD
1. NAME OF DECEASED (Type or Print) <b>Madora Owens</b>		2. DATE AND HOUR OF DEATH <b>December 9, 1972</b> <span style="float: right;">A M.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>90 MidTown Nursing Home 808 St. Paul Street</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md</b> B. COUNTY <b>Anne Arundel</b> <span style="float: right;">5210</span> C. CITY OR TOWN <b>Annapolis</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>35 Hicks Ave</b>		
5. SEX <b>F</b>	6. RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-11-1885</b>	9. AGE (In years last birthday) <b>87</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Md</b>
13. FATHER'S NAME <b>Dodie Owens</b>		14. MOTHER'S MAIDEN NAME <b>Alice Harried</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>Unkn</b>		17. INFORMANT ADDRESS <b>Anna, Md</b> <b>Mrs Georgianna Brooks 46 Parole Street</b>
18. <b>412.2 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cardio Respiratory Failure</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Hypertensive- Art C.U.I.C.</b> <b>Gen &amp; Cervical Arteriosclerosis</b> <b>Parkinson's Disease</b> <b>Senile</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>May 22</b> 19 <b>69</b> to <b>Dec 9</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>Dec 9</b> 19 <b>72</b> and that in (my) ( ) opinion death occurred on the date and hour and from the causes stated above. (I) ( ) (did not) view the body after death.				
23A. SIGNATURE <b>William D. Appleford</b>				23B. DATE SIGNED <b>12-10-1972</b>
23C. PHYSICIAN'S NAME (Type) <b>William D. Appleford</b>		23D. ADDRESS <b>6615 Reisterstown Rd</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>12-12-1972</b>	24C. NAME OF CEMETERY or CREMATORY <b>Pinelawn Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Annapolis, Md</b>
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 18 1972</b>		25B. NAME OF REGISTRAR <b>Sidney Whitcomb</b>		25C. FUNERAL DIRECTOR ADDRESS <b>O.E. Hicks, 411 1922 Forest Drive, Anna, Md</b>

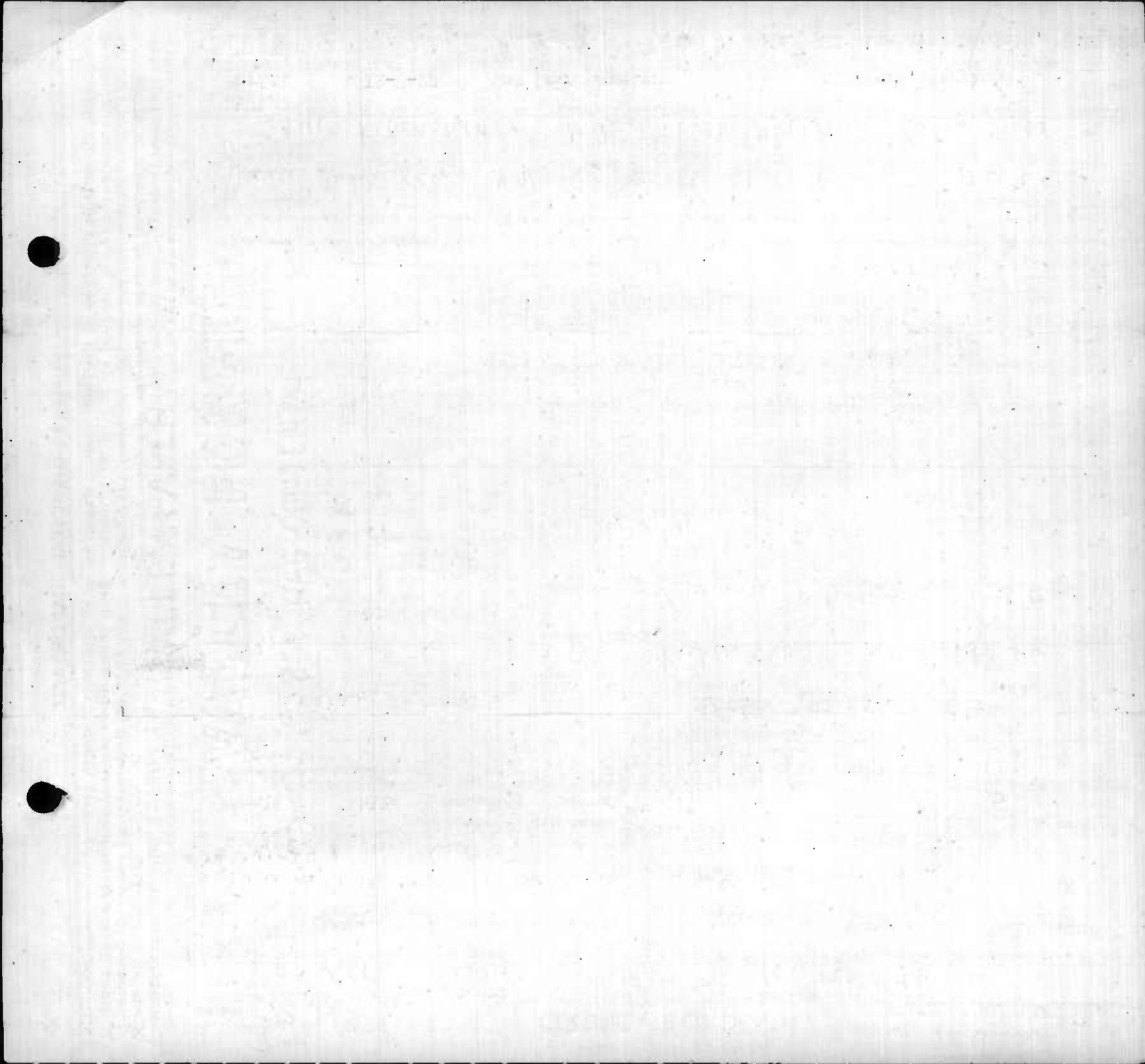


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72-11951	
B.C. 72-17904				72-11951	
BIRTH NO. 72 11951				STATE OF MARYLAND-DEMD	
1. NAME OF DECEASED (Type or Print) <u>Susan E. Rogers</u> <u>Rogers, Susan</u>			2. DATE AND HOUR OF DEATH <u>12.6.72</u> <u>740 PM</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore Co.</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>John Hopkins Hospital - Children Med &amp; Surg Center</u>			C. CITY OR TOWN <u>Dundalk</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
			E. STREET AND NUMBER <u>7829 W. Collingham Dr.</u> <u>5300</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12.1.72</u>	9. AGE (In years last birthday) <u>5</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dependent</u>			11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? <u>US</u>		
13. FATHER'S NAME <u>Rogers Raymond</u>			14. MOTHER'S MAIDEN NAME <u>Elizabeth Murray</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>No</u>		
			17. INFORMANT <u>Rubenstein</u> ADDRESS <u>JHH BM 316</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>747.61</u> CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Congenital A-V Fistula</u> (B) <u>Seizures, Heart Failure</u> (C) <u>5 days</u> DUE TO, OR AS A CONSEQUENCE OF: APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u> <u>No</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>No</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>No</u>					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At <input type="checkbox"/> Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>12.1</u> 19 <u>72</u> to <u>12.6</u> 19 <u>72</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>12.6</u> 19 <u>72</u> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <u>James Rubenstein, M.D.</u>			23B. DATE SIGNED <u>12.6.72</u>		
23C. PHYSICIAN'S NAME (Type) <u>JAMES RUBENSTEIN, M.D.</u>			23D. ADDRESS <u>1518 McElderry Balto 2205</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-8-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>	
24D. LOCATION <u>Baltimore, Maryland</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 18 1972</u>		25B. NAME OF REGISTRAR <u>Lidny</u>		25C. FUNERAL DIRECTOR <u>John J. Duda</u> ADDRESS <u>7922 Wise Ave. Dundalk, Md. 21222</u>	

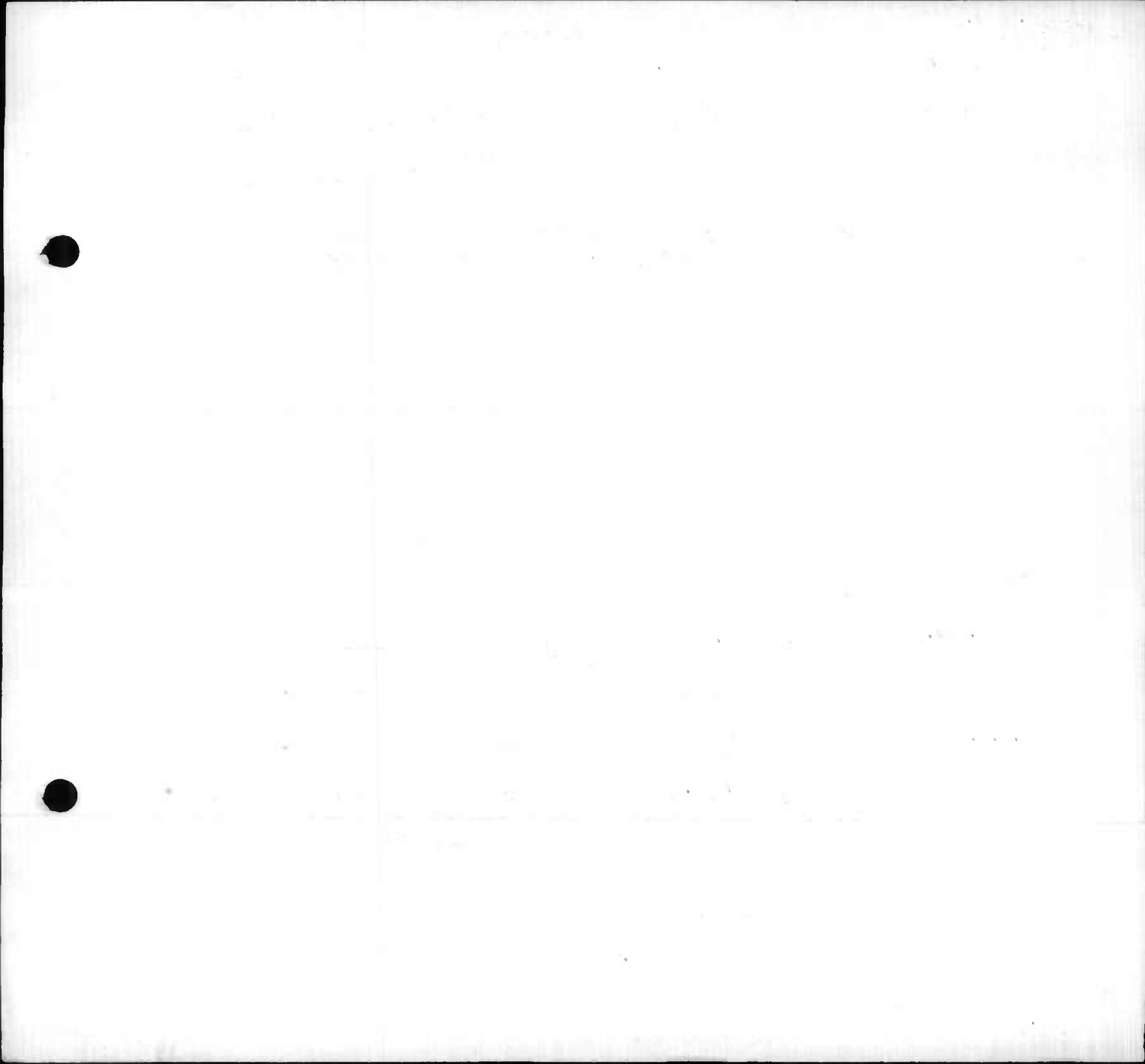






This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-6201		72 11952		BALTIMORE CITY HEALTH DEPARTMENT		72 11952	
CERTIFICATE OF DEATH				REG. NO.		STATE OF MARYLAND-DHMH	
1. NAME OF DECEASED (Type or Print) <i>Parrish Martha E.</i>				2. DATE AND HOUR OF DEATH <i>12-14-72 2:55 P.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>90 Harbor View Nursing Home</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>2404</i>			
				C. CITY OR TOWN <i>Baltimore 21230</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>1826 Byrd Street</i>			
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Feb. 10, 1881</i>	9. AGE (In years last birthday) <i>91</i>	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John F. Wright</i>				14. MOTHER'S MAIDEN NAME <i>Mammie Schindollar</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>?</i>		17. INFORMANT <i>John F. Parrish</i>		ADDRESS <i>1826 Byrd Street Balto., Md. 21230</i>	
18. <i>412.2 I</i> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>ASCVD with hypertension and CHF</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Years</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (it) (this hospital) attended the deceased from <i>March 12</i> 19 <i>71</i> to <i>December 14</i> 19 <i>72</i> that (it) (we) last saw the deceased alive on <i>December 14</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (it) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Peter H. Rheinstein, M.D.</i>				Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>14 Dec 1972</i>	
23C. PHYSICIAN'S NAME (Type) <i>PETER H. RHEINSTEIN, MD</i>				23D. ADDRESS <i>HARBOR VIEW NURSING HOME</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12-18-72</i>		24C. NAME OF CEMETERY or CREMATORY <i>Meadowridge Mem. Park</i>		24D. LOCATION (City, town, or county) (State) <i>Howard County, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 18 1972</i>		25B. NAME OF REGISTRAR <i>Andrew H. Hinton</i>		25C. FUNERAL DIRECTOR <i>McGully Funeral Home</i>		ADDRESS <i>130 East Fort Avenue Balto., Md. 21230</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 11953</u>	
BIRTH NO. <u>72 11953</u>				STATE OF MARYLAND - DHMH	
CERTIFICATE OF DEATH				12-17-72 3:45 PM	
1. NAME OF DECEASED (Type or Print) <u>KOENIG NORMAN A.</u>				2. DATE AND HOUR OF DEATH	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>UNIVERSITY OF MARYLAND HOSPITAL</u>				C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>517 CALLEMAN ST.</u>					
5. SEX <u>M</u>	6. RACE <u>CAUCASIAN</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-20-11</u>	9. AGE (In years last birthday) <u>61</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BARTENDER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Liquor</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>Henry Koenig</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war & dates of service) <u>NO</u>				14. MOTHER'S MAIDEN NAME <u>Anna Flathman</u>	
16. SOCIAL SECURITY NO. <u>215-07-0481</u>				17. INFORMANT <u>P. RAY CHUNG</u> ADDRESS <u>7 LEONARD RD HARVARD RD</u>	
18. <u>571.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last				CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>UREMIA</u> DUE TO, OR AS A CONSEQUENCE OF: <u>RENAL FAILURE</u> (B) <u>HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF: <u>CIRRHOSIS</u> (C) <u>CHRONIC OBSTRUCTIVE PNEUMONIA, PULMONARY HTN</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>CHRONIC OBSTRUCTIVE PNEUMONIA, PULMONARY HTN</u>					
19A. DATE OF OPERATION <u>None</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>None</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>None</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>None</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>None</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>None</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> <u>None</u>		21F. HOW DID INJURY OCCUR? <u>None</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>11-21/1140 AM 1972</u> to <u>12-17/3:45 PM 1972</u> that (I) (we) lost saw the deceased alive on <u>12-17</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>				23B. DATE SIGNED <u>12-17-72</u>	
23C. PHYSICIAN'S NAME (Type) <u>TOEL SCHAPIRA</u>				23D. ADDRESS <u>UNIVERSITY OF MARYLAND HOSPITAL LUTHERAN FREEMAN ST. BALTIMORE MD 21201</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/20/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>London Park Cem.</u>	
24D. LOCATION (City, town, or county) <u>Baltimore, Md.</u>		24E. DATE REC'D BY HEALTH DEPT. <u>DEC 18 1972</u>		25A. NAME OF REGISTRAR <u>Sidney [Signature]</u>	
25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR <u>John J. Brown &amp; Son Inc.</u>		25D. ADDRESS <u>901 St. Hollist</u>	



1  
6-610

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

(Jerry Eugene) GEORGE GRUBB

2. DATE

Known ☒

Month

Day

Year

Hour

OF DEATH

Estimated ☐

December 13, 1972

2:30 P. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

48 Maryland General Hospital

3. DATE PRONOUNCED DEAD

December 13, 1972

2:30 P. M.

5. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission)

A. STATE Maryland

B. COUNTY

0000

6. SEX

Male

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☒

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

March 26, 1948

10. AGE (In years last birthday)

24

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

Unknown

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

David G. Grubb

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Tree Trimmer

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Rosetta Whitaker

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL SECURITY NO.

18. INFORMANT

ADDRESS

Rosetta Whitaker Grubb - Mother

19. E965X

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE Gunshot wound of abdomen  
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

1

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Street

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

Lafayette &amp; Charles

22D. TIME (Month) (Day) (Year) (Hour)

OF INJURY (APPROX.)

12-13-72

2:35 A.

22E. INJURY OCCURRED WHILE AT WORK ☐NOT WHILE AT WORK ☒

22F. HOW DID INJURY OCCUR?

Shot after altercation

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Ronald N. Kornblum, M.D.

Deputy CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

December 14, 1972

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

12-16-72

24C. NAME of CEMETERY or CREMATORY

Greenwood Cemetery

24D. LOCATION (City, town, or county) (State)

Washington Co., Virginia

25A. DATE REC'D BY HEALTH DEPT.

DEC 18 1972

25B. NAME OF REGISTRAR

Sidney H. Kornblum

25C. FUNERAL DIRECTOR

Metropolitan Funeral Service

ADDRESS

65597 Vine Street Alexandria, Va.





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 11955	
72 11955				STATE OF MARYLAND-DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Ella E. Surland		12/14/72 6:30p M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) South Baltimore General H.				A. STATE MD	
				B. COUNTY ANNE ARUNDEL	
5. SEX F				6. RACE W	
				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)	
Housewife				Baltimore, MD.	
13. FATHER'S NAME James Kaiser				14. MOTHER'S MAIDEN NAME Barbara XXXXXXXX	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 213-05-6523-D	
17. (INFORMANT Mrs. June James (daughter)				ADDRESS Glen Burnie, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 162.1 I possible myocardial infarction or pulmonary insufficiency. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) Carcinoma of the R Lung DUE TO, OR AS A CONSEQUENCE OF: (C) and Carcinoma of R Kidney APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 11/2/13/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of R Kidney		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/31/72 1972 to 12/14/1972 that (I) (we) last saw the deceased alive on 12/14/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Hidalgo				23B. DATE SIGNED 12/14/72	
23C. PHYSICIAN'S NAME (Type) Cesar Hidalgo M.D.				23D. ADDRESS South Baltimore General H.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/18/72		24C. NAME OF CEMETERY OR CREMATORY GLEN HAVEN MEMORIAL PARK	
24D. LOCATION (City, town, or county) (State) GLEN BURNIE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. DEC 18 1972			
25B. NAME OF REGISTRAR Sidney [Signature]		25C. FUNERAL DIRECTOR [Signature] SINGLETON FUNERAL HOME GLEN BURNIE, MD.			



*Handwritten signature*

15/11/51  
15/11/51  
15/11/51

15/11/51

James Keizer  
Holkville  
F M X

Waltham  
Waltham  
11/10/53

12 Waltham 20th Nov 59

12 Waltham 20th Nov 59  
12 Waltham 20th Nov 59

Elide

15/11/51

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					REG. NO. 72 11956				
BIRTH NO. 72 11956					STATE OF MARYLAND-DHMH				
1. NAME OF DECEASED (Type or Print) <b>WALTER L. PARDOE</b>					2. DATE AND HOUR OF DEATH <b>12/14/72 5:55 P.M.</b>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>SOUTH BALTIMORE GENERAL HOSPITAL</b>					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>ANNE ARUNDEL</b> C. CITY OR TOWN <b>GLEN BURNIE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>1004 Edgerly Rd. (HARUNDALE)</b>				
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-19-08</b>	9. AGE (In years last birthday) <b>64 yrs.</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired GUARD</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Robert PARDOE</b>					14. MOTHER'S MAIDEN NAME <b>Laura Buckler</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>					16. SOCIAL SECURITY NO. <b>220.D7.7898</b>				
17. INFORMANT <b>Mrs. Louise C. Pardoe (wife)</b>					ADDRESS <b>Same As #4</b>				
18. <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>GENERAL VASCULAR ACCIDENT</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(B) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE SEVERAL YRS.</b> <b>(C) CHRONIC OBSTRUCTIVE PULMONARY DISEASE SEVERAL YRS.</b>					CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 WK.</b>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <b>0</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <b>NO.</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>12/12</b> 19 <b>72</b> to <b>12/14</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>12/14</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Robert J. Bauer, M.D.</b>								23B. DATE SIGNED <b>12/14/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>ROBERT J. BAUER, M.D.</b>								23D. ADDRESS <b>3001 S. HANOVER ST. BALTIMORE, MD. 21230</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>			24B. DATE <b>12.18.72</b>			24C. NAME OF CEMETERY or CREMATORY <b>GLEN HAVEN MEM. PARK</b>			24D. LOCATION (City, town, or county) (State) <b>GLEN BURNIE, MARYLAND</b>
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 18 1972</b>			25B. NAME OF REGISTRAR <b>Andrew Whitton</b>			25C. FUNERAL DIRECTOR <b>Singleton Funeral Home</b>			<b>GLEN BURNIE, MD.</b>

*Handwritten signature or initials*

*Vertical handwritten text, possibly a date or reference number*

*Faint handwritten text in the lower right quadrant*

# FUNERAL DIRECTOR: IMPORTANT

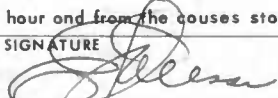
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

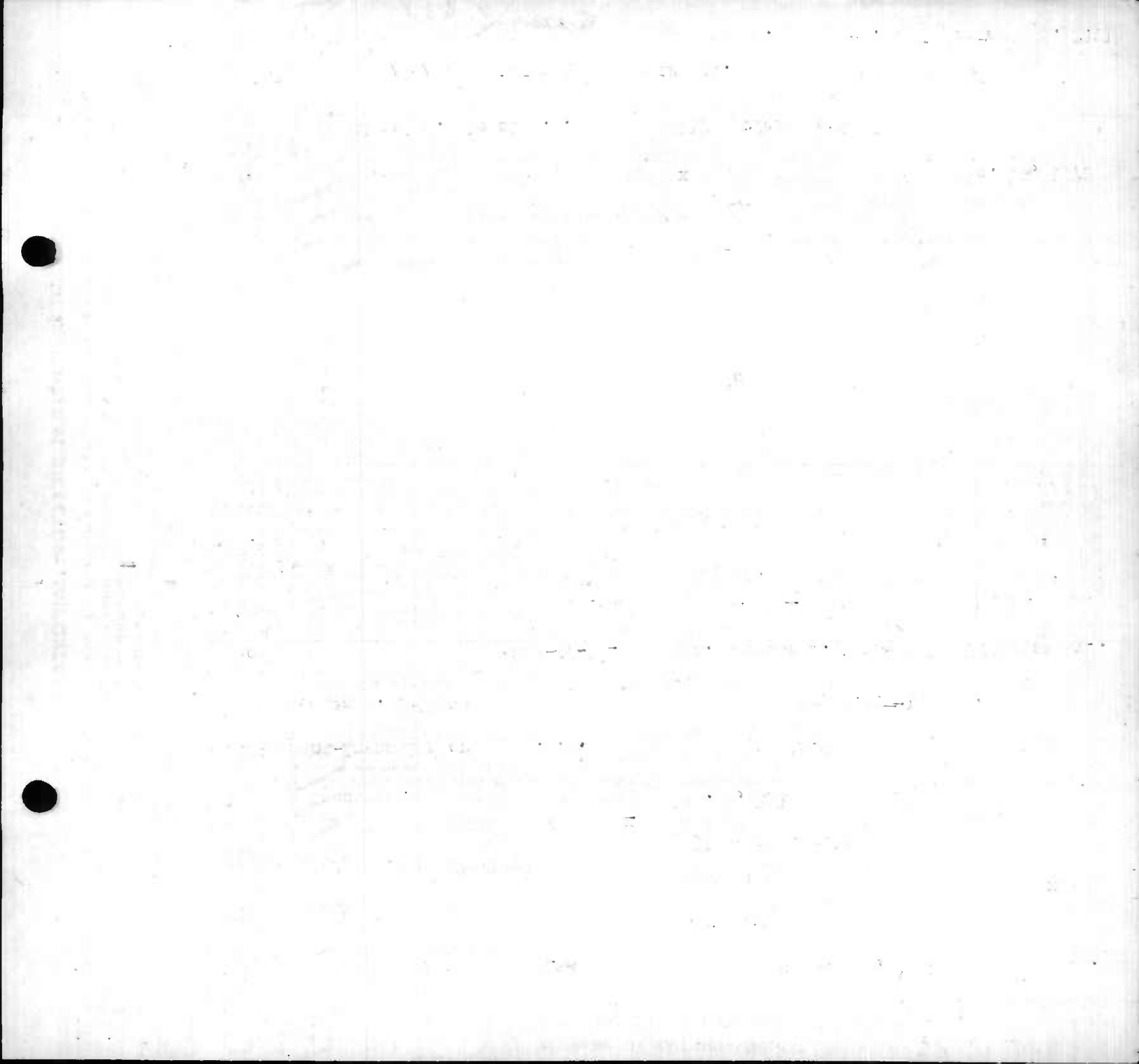
BIRTH NO. 72 11957		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 11957	
CERTIFICATE OF DEATH		STATE OF MARYLAND - DEPT. OF HEALTH			
1. NAME OF DECEASED (Type or Print) <i>Daukantas Anna</i>		2. DATE AND HOUR OF DEATH <i>12/16/72 6:50 A. M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <i>Haber View Nursing Home</i>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>BALTO</i> C. CITY OR TOWN <i>Balto.</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>1209 Dalton Rd.</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Haber View Nursing Home</i>		5. SEX <i>F</i> 6. RACE <i>M.</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <i>3/21/1890</i> 9. AGE (In years last birthday) <i>82</i> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Seamstress</i> 11. BIRTH PLACE (State or foreign country) <i>Lithuania</i> 12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>			
13. FATHER'S NAME <i>Kazimieras Idzelis</i>		14. MOTHER'S MAIDEN NAME <i>Petronela Zeimyte</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>215-03-0036</i>		17. INFORMANT <i>Albert Daukantas</i> ADDRESS <i>21234</i>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Septicemia from severe decubitus ulcer</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 months</i>	
(B) <i>chronic alcoholism</i>		DUE TO, OR AS A CONSEQUENCE OF:		<i>months</i>	
(C) <i>arteriosclerosis</i>		DUE TO, OR AS A CONSEQUENCE OF:		<i>years</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. A. <i>asphyxia</i>					
19A. DATE OF OPERATION <i>10/22/72</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>gangrene left leg</i>		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>12/11/72</i> to <i>12/16/72</i> and that (I) (we) last saw the deceased alive on <i>12/16/72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>ALLAN H. MACHT MD</i>		23B. DATE SIGNED <i>12/16/72</i>		23C. PHYSICIAN'S NAME (Type) <i>ALLAN H. MACHT MD</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>burial</i>		24B. DATE <i>12/20/72</i>		24C. NAME of CEMETERY or CREMATORY <i>Holy Redeemer Cem.</i>	
24D. LOCATION <i>Balto. Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>DEC 18 1972</i>		25B. NAME OF REGISTRAR <i>Lindsey Johnston</i>	
25C. FUNERAL DIRECTOR <i>John J. Brown</i>		25D. ADDRESS <i>Ln Inc 901, Haller Co. Balto. Md.</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

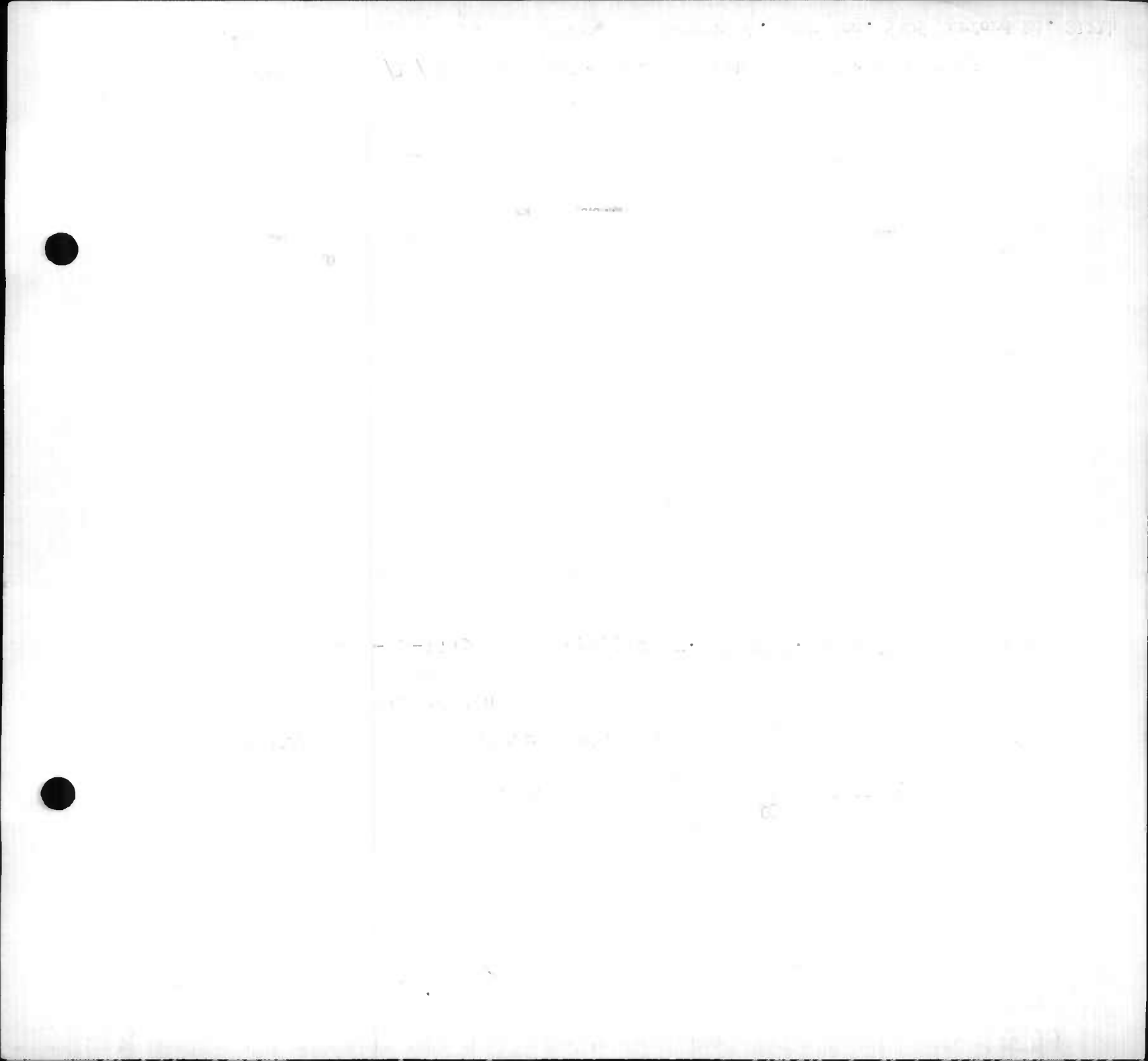
BALTIMORE CITY HEALTH DEPARTMENT				72 11958	
CERTIFICATE OF DEATH				REG. NO. 72 11958	
BIRTH NO. 72 11958		STATE OF MARYLAND - DEPT. HEALTH			
1. NAME OF DECEASED (Type or Print) <b>James Henry Coleman</b>		2. DATE AND HOUR OF DEATH <b>December 13, 1972 7:00 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>44 Union Memorial Hospital</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>BALTO</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>131 Solar Circle</b>			
5. SEX <b>Male</b>	6. RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 5, 1916</b>	9. AGE (In years last birthday) <b>56</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Special Agent-Investigator</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>D.M.V.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>James H. Coleman</b>		14. MOTHER'S MAIDEN NAME <b>Mary Patzwell</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-07-3445</b>		17. INFORMANT <b>Mrs. Loretta C. Hyatt 2918 Hillcrest Ave.</b>	
18. <b>395.9 14250.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Congestive Heart Failure</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arterio valve disease</b> <b>sistole</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Feb 1972</b> <b>Feb 1972</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Sept 13 1943</b> to <b>Dec 13 1972</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>Dec 13 1972</b> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. <del>(We)</del> (We) (did) <del>(did not)</del> view the body after death.					
23A. SIGNATURE  <b>Edward J. Alessi M.D.</b>				23B. DATE SIGNED <b>Dec. 14, 1972</b>	
23C. PHYSICIAN'S NAME (Type) <b>Edward J. Alessi M.D.</b>				23D. ADDRESS <b>6217 Harford Road</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/16/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Most Holy Redeemer Cem.</b>	
24D. LOCATION <b>Baltimore Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 18 1972</b>			
25B. NAME OF REGISTRAR <b>Sidney J. Horton</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Buck Inc. 5305 Harford Rd. 21214</b>			





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

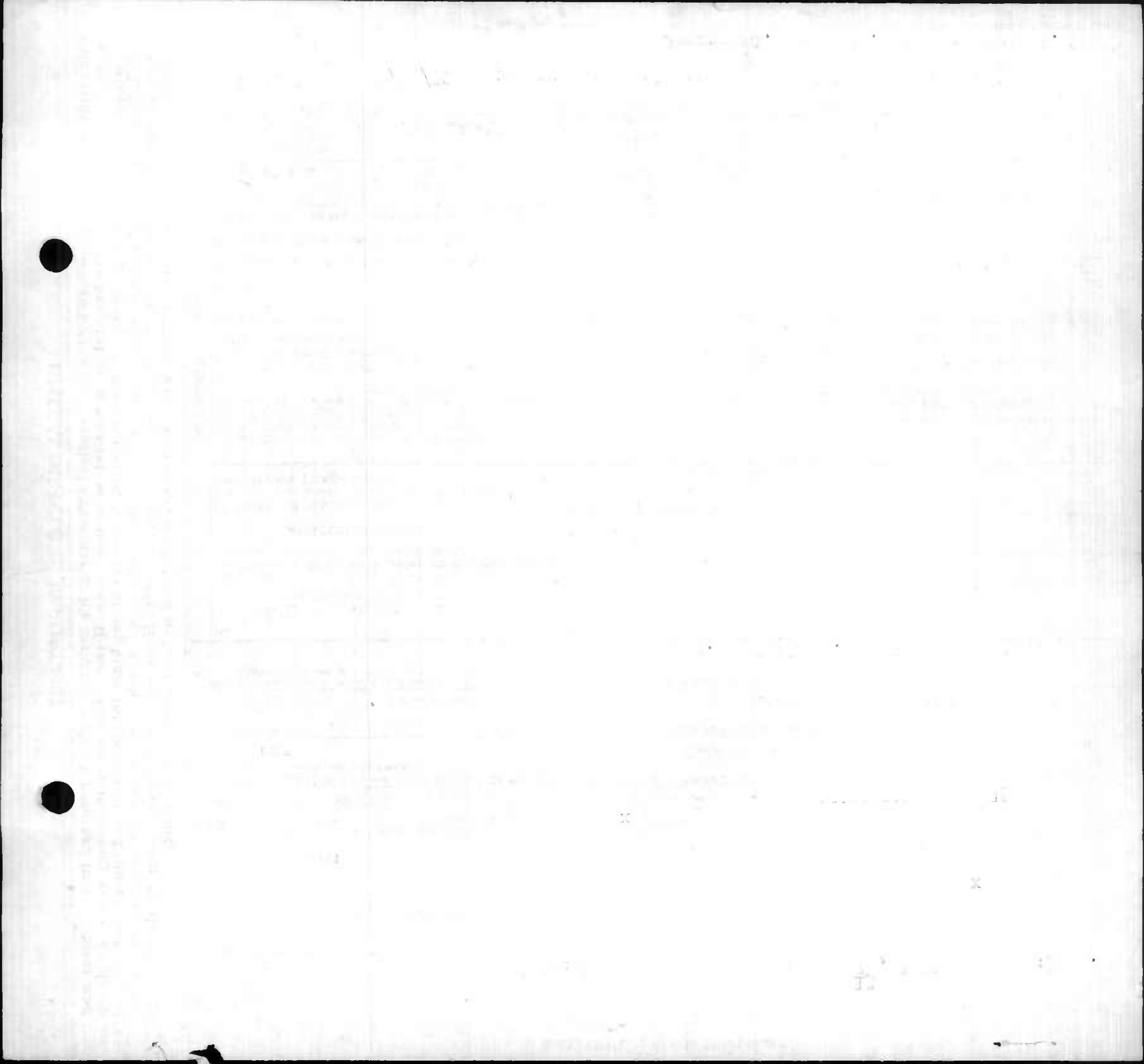
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				STATE OF MARYLAND - <del>DIHE</del>	
BIRTH NO. <u>72 11959</u>		REG. NO. <u>72 11959</u>			
1. NAME OF DECEASED (Type or Print) <u>MARIE E. DIETRICH</u>		2. DATE AND HOUR OF DEATH <u>12/13/72</u> <u>11 10 P M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <u>UNIVERSITY of MD. Hospital.</u> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <u>38</u>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>2003</u> C. CITY OR TOWN <u>BALTO</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>616 S. PAYSON ST.</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/27/103</u>	9. AGE (In years last birthday) <u>69</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>XXXXXXXXXX</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Homemaker &amp; Saleslady</u>		11. BIRTHPLACE (State or foreign country) <u>W. Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John Dillon</u>		14. MOTHER'S MAIDEN NAME <u>HATTIE</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>NO</u> If yes, give war or dates of service <u>216-03-1115</u>		16. SOCIAL SECURITY NO. <u>XXXXXXXXXX</u>		17. INFORMANT <u>Mr. Robert C. Campbell</u> ADDRESS <u>Same</u>	
18. <u>430.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>INTRACEREBRAL hematoma</u> DUE TO, OR AS A CONSEQUENCE OF: <u>a Ruptured HEMORRHOID.</u> (B) <u>Blending int. carotid aneurysm</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Subarachnoid hemorrhage.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20A. AUTOPSY? (Yes or No) <u>?</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that (this hospital) attended the deceased from <u>11/27/72</u> 19__ to <u>12/13/72</u> 19__ that (I) <u>last</u> saw the deceased alive on <u>12/13</u> 19__ <u>72</u> and that in (my) <u>last</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(did)</u> view the body after death.					
23A. SIGNATURE <u>Allan Genut</u>		23B. DATE SIGNED <u>12/14/72</u>		23C. PHYSICIAN'S NAME (Type) <u>ALLAN GENUT</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/16/72</u>		24C. NAME of CEMETERY or CREMATORY <u>Meadowridge Memorial Park</u>	
24D. LOCATION <u>Baltimore Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 18 1972</u>		25B. NAME OF REGISTRAR <u>Edney Houston</u>	
25C. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc.</u>		25D. ADDRESS <u>5305 Harford Rd. 21214</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 72 11960	
72 11960				STATE OF MARYLAND-DMHM	
BIRTH NO. BC 72-17644				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>BABY GIRL HANDLEY (Stacy)</b>			2. DATE AND HOUR OF DEATH <b>December 12, 1972 9:35 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>SOUTH BALTIMORE GENERAL HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2642</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>PLAINFIELD AVE - 4336</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-23-72</b>	9. AGE (In years last birthday) <b>2000 days</b>	10. Under 1 Yr. Months: <b>19</b> Days: <b>19</b> Hours: <b>19</b> Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>			10B. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>REGINALD J. HANDLEY</b>			14. MOTHER'S MAIDEN NAME <b>JANIS E. Craig</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Reginald J. Handley</b>
18. <b>741.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>HYDROCEPHALUS +</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>MEDINOMYOCLOGL / multiple</b> <b>Congenital anomalies</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If only medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>11-23</b> 19 <b>72</b> to <b>12-13</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>12-13</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Uirma V. Torres</b> <b>M.D.</b>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>UIRMA V. TORRES</b>				23D. ADDRESS <b>MD SOUTH BALTI. GEN. HOSP., BALTI. MD, 21230</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/14/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Park</b>	
24D. LOCATION <b>Baltimore Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 18 1972</b>			
25B. NAME OF REGISTRAR <b>Leonard J. Ruck Inc.</b>		25C. FUNERAL DIRECTOR <b>5305 Harford Rd. 21214</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

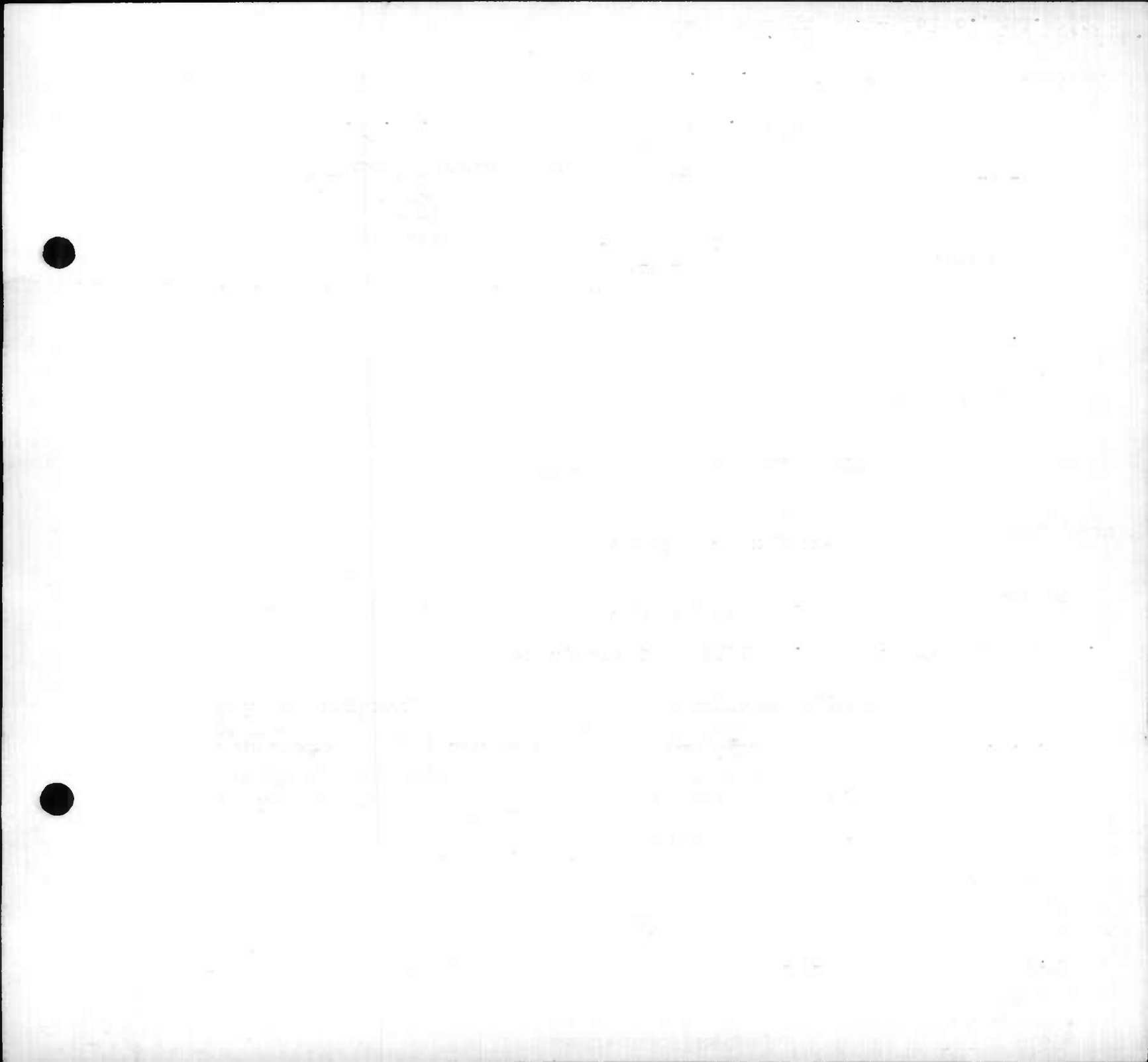
BALTIMORE CITY HEALTH DEPARTMENT				72 11961
CERTIFICATE OF DEATH				REG. NO. 72 11961
BIRTH NO. 72 11961		STATE OF MARYLAND-DEATH		
1. NAME OF DECEASED (Type or Print) <b>LANG HARRY M.</b>		2. DATE AND HOUR OF DEATH <b>12-13-72 3:30 a.m.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>The Union Memorial Hospital.</b>		A. STATE <b>MARYLAND</b> B. COUNTY <b>2733</b>		
		C. CITY OR TOWN <b>BALTIMORE.</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <b>4700 HARFORD ROAD, Baltimore, MD 21214</b>		
5. SEX <b>Male.</b>	6. RACE <b>white.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 12, 1895</b>	9. AGE (In years last birthday) <b>77</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired.</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
13. FATHER'S NAME <b>Martin Lang</b>		14. MOTHER'S MAIDEN NAME <b>Hannah Rediger</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-14-6614</b>		17. INFORMANT <b>Evelyn Buff</b>
				ADDRESS <b>2613 HALCYON Avenue Baltimore, MD 21214</b>
18. <b>486X I</b>		CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <b>Cran. negative Bilateral Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		
		(C)		
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (H) (this hospital) attended the deceased from <b>November 22, 1972</b> to <b>December 13, 1972</b> , that (H) (We) last saw the deceased alive on <b>December 13, 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Walter Castillo</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>12-13-72</b>
23C. PHYSICIAN'S NAME (Type) <b>WALTER CASTILLO</b>		23D. ADDRESS <b>Union Memorial Hospital Calvert and 33rd Street Baltimore, MD 21218</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>12/15/72</b>	24C. NAME OF CEMETERY or CREMATORY <b>Baltimore Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 18 1972</b>		25B. NAME OF REGISTRAR <b>Sidney H. Heston</b>		
		25C. FUNERAL DIRECTOR'S ADDRESS <b>Robert C. Altenburg Funeral Home, Inc. 6009 Harford Rd. Balto., Md. 21214</b>		

9/21/71 - 4PH  
2613 HILTON AVE.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-500 1		72 11962		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 11962	
CERTIFICATE OF DEATH				STATE OF MARYLAND - <del>DEPT</del>			
1. NAME OF DECEASED (Type or Print)		Minnie Louise Boehm		2. DATE AND HOUR OF DEATH		12-13-72 6:00 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE Maryland			
44 Union Memorial Hospital				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				4706 Hellwig Rd.			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Min.
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	3/31/1891	81			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife		Own home		Maryland		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Julius Daugherty				Margaret Ruppert			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No		215-09-2951		B William A. Boehm-4706 Hellwig Rd.			
18. <u>436.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				Cerebral vascular accident			
ANTECEDENT CAUSES				(A) IMMEDIATE CAUSE			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				DUE TO, OR AS A CONSEQUENCE OF:			
				hypertension of many years			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
				one day			
				many years			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from <u>3-21-69</u> to <u>present</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>12-1</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
<i>Dr. A. N. Rahman</i>						12-14-72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Dr. A. N. Rahman				100 N. Broadway			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		12/18/72		Dulaney Valley Mem. Cem.		Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
DEC 18 1972		<i>Andrew H. ...</i>		Robert G. Altenburg Funeral Home, Inc.		6009 Harford Rd. - Balto., Md. 21214	





K-5001

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 72 11963

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JOHN ROBERT KEEN III

2. DATE AND HOUR OF DEATH  
Dec. 12, 1972

STATE OF MARYLAND - DEPT. OF HEALTH

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

US Public Health Service Hospital  
3100 Wyman Parkway

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY  
Md.

C. CITY OR TOWN  
Baltimore

D. INSIDE CITY LIMITS?  
YES ☒ NO ☐

E. STREET AND NUMBER  
2495 Perring Manor Rd.

5. SEX

M

6. RACE

Caucasian

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

12/4/10

9. AGE (in years last birthday)

62

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
Machinist

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)  
Aberdeen, Md.

12. CITIZEN OF WHAT COUNTRY?  
USA

13. FATHER'S NAME

John Robert Keen

14. MOTHER'S MAIDEN NAME

Laura Taylor

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  
No

16. SOCIAL SECURITY NO.  
136-05-2010

17. INFORMANT ADDRESS  
Records- US PHS Hospital, Balto, Md.

18. 162.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

Acute bronchopneumonia, bilateral

(A) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  
Days

(B) Anaplastic carcinoma of the left  
DUE TO, OR AS A CONSEQUENCE OF: upper lobe, widely metastatic

Unknown

(C)

Renal failure, acute

Days

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)  
yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  
yes

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Nov. 10 19 72 to Dec. 12 19 72 that (I) (we) last saw the deceased alive on Dec. 12 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

23C. PHYSICIAN'S NAME (Type)

Robert Wright, MD

DEGREE

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED  
12/13/72

23D. ADDRESS

US PHS Hospital, Balto, Md.

24A. BURIAL CREMATION, REMOVAL (Specify)  
Burial

24B. DATE

15 Dec 72

24C. NAME OF CEMETERY or CREMATORY

Speshtia Episcopal Cem

24D. LOCATION

Perryman, Harford, Maryland

(City, town, or county) (State)

25A. DATE RECEIVED BY HEALTH DEPT.

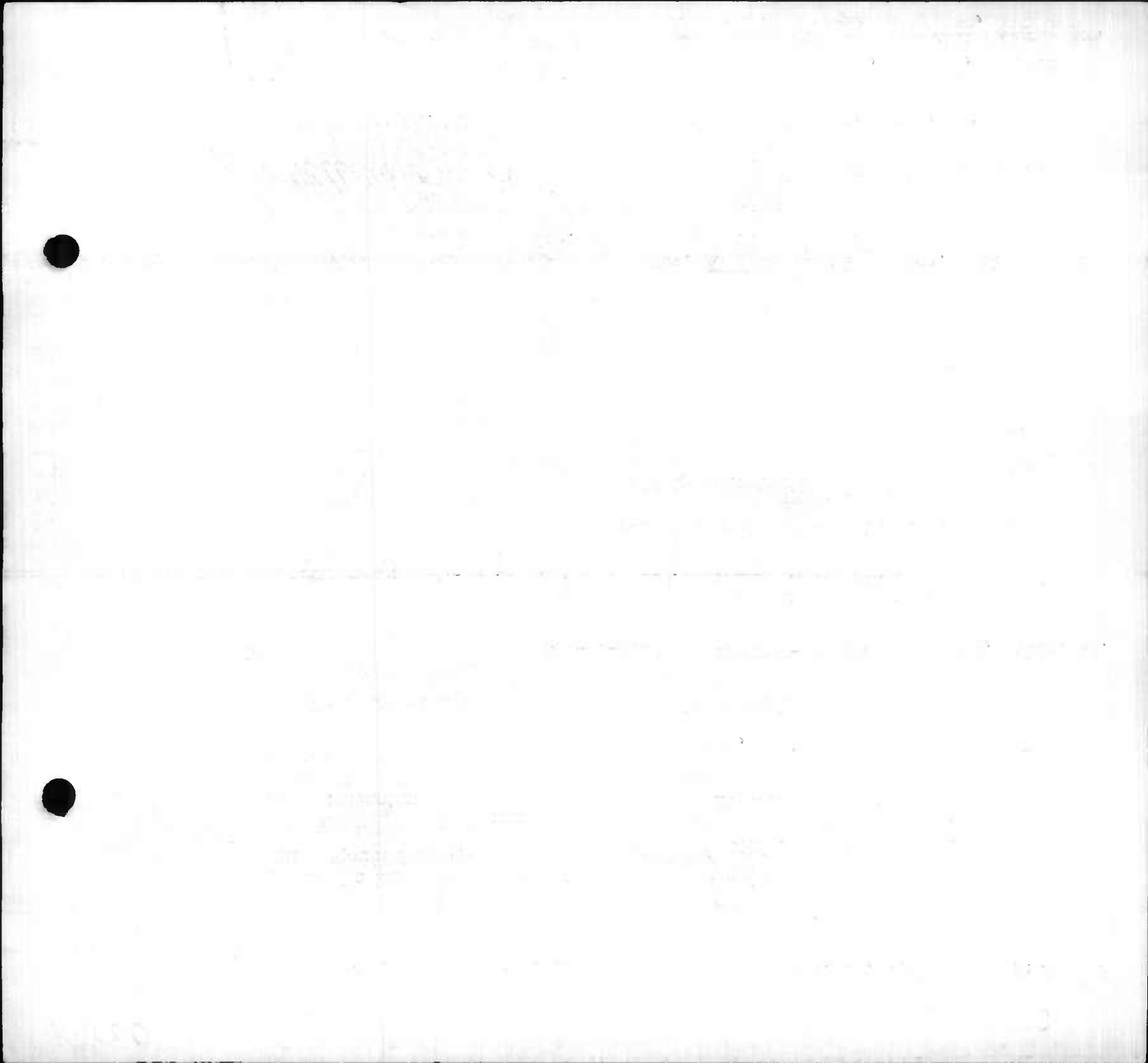
DEC 18 1972

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

Tarring Funeral Home

Aberdeen, Maryland



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 11964</u>	
BIRTH NO. <u>72 11964</u>				STATE OF MARYLAND-DHMH	
1. NAME OF DECEASED (Type or Print) <b>GALINAITIS, PETRONE</b>			2. DATE AND HOUR OF DEATH <b>DECEMBER 13, 1972 11:10A</b> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>40 ST. AGNES HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>1245 VOGT AVE 21227</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>CAUCASIAN</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>06/08/98</b>	9. AGE (In years last birthday) <b>74</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) <b>LITHUANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>LITHUANIA</b>
13. FATHER'S NAME <b>ROBERTAS MAJAUSKAS</b>			14. MOTHER'S MAIDEN NAME <b>ONA KLASAVICIUS</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NONE</b>			16. SOCIAL SECURITY NO. <b>172-26-7414</b>		17. INFORMANT ADDRESS <b>CATON &amp; WILKENS AVES. BALTO, MD 21229</b>
18. <b>519.31</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  <b>CAUSE OF DEATH</b> <b>COPD Dehydration</b> <b>CO PD congestive heart failure</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>DECEMBER 12 1972</b> to <b>DECEMBER 13 1972</b> , that (I) (we) last saw the deceased alive on <b>DECEMBER 13 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Kuang-yen Huang</b>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>Kuang-yen Huang</b>				23D. ADDRESS <b>BALTIMORE, MD 21229</b> <b>ST. AGNES HOSPITAL; CATON &amp; WILKENS AVES</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12/16/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>NEW CATHEDRAL</b>	
24D. LOCATION (City, town, or county) (State) <b>FREDRICK RD</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 18 1972</b>		25B. NAME OF REGISTRAR <b>Sidney [Signature]</b>	
25C. FUNERAL DIRECTOR <b>THOMAS J. KENNYING</b>		ADDRESS <b>1600 HOLLINS ST.</b>			

ST. VICTOR HOSPITALIZATION & NICKER AVE  
BUTLINGTON, MD 21713

DECEMBER 12 1977

DECEMBER 14 1977

ONE

12-1-1977

ST. VICTOR HOSPITALIZATION & NICKER AVE  
BUTLINGTON, MD 21713

DECEMBER 14 1977

ONE

DECEMBER 14 1977

DECEMBER 14 1977

DECEMBER 14 1977

DECEMBER 14 1977

DECEMBER 14 1977

DECEMBER 14 1977

DECEMBER 14 1977

DECEMBER 14 1977

DECEMBER 14 1977

DECEMBER 14 1977

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 11965	
CERTIFICATE OF DEATH				REG. NO. 72 11965	
STATE OF MARYLAND-DHMH					
BIRTH NO. 72 11965					
1. NAME OF DECEASED (Type or Print) <b>LAWSON, GROVER CLEVELAND</b>		2. DATE AND HOUR OF DEATH <b>DECEMBER 15, 1972 8:05 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>40 ST AGNES HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2572</b>			
		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>3035 LORENA AVENUE 21230</b>			
5. SEX <b>MALE</b>	6. RACE <b>CAUCASIAN</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11 05 91</b>	9. AGE (In years last birthday) <b>81</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RIGGER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>GENERAL Ship Co.</b>		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>	
13. FATHER'S NAME <b>OCTAVIS LAWSON</b>		14. MOTHER'S MAIDEN NAME <b>BETTY RICHARDSON</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216 09 7922</b>		17. INFORMANT <b>ST AGNES HOSPITAL RECORDS CATON AND WILKENS AVES BALTO MD 21229</b>	
18. <b>470X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Influenzae</b> DUE TO, OR AS A CONSEQUENCE OF:  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <b>XX</b> (this hospital) attended the deceased from <b>12 07</b> 19 <b>72</b> to <b>12 15</b> 1972, that <b>XX</b> (we) last saw the deceased alive on <b>12 15 72</b> 19 and that in <b>XX</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>X</b> (We) (did) ( <b>XXX</b> ) view the body after death.					
23A. SIGNATURE <b>[Signature]</b>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>DR. BUCKLER</b>				23D. ADDRESS <b>ST AGNES HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>DEC. 18 72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>GLEN HAVEN</b>	
24D. LOCATION (City, town, or county) (State) <b>RITCHIE HWY - GLEN BURNIE MD</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 18 1972</b>			
25B. NAME OF REGISTRAR <b>Sidney [Signature]</b>		25C. FUNERAL DIRECTOR <b>Barb A. [Signature] 1216 S. Charles St 21230</b>			

ST. JAMES HOSPITAL

X XX  
15 12 37

15 01

15 12

15 12

NO

NO

312 06 1353

MICHIGAN 0110 11 1933

ST. JAMES HOSPITAL, 2002 12 1933

OSCAR L. JAMES

OSCAR L. JAMES

VIRGINIA

11 12 37

DATE

OSCAR L. JAMES

X

11 02 31

18

2002 12 1933

ST. JAMES HOSPITAL

ST. JAMES HOSPITAL

X

11 12 37

OSCAR L. JAMES

2002 12 1933

11 12 37



2-163 1

72 11966

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

72 11966

STATE OF MARYLAND - DHMH

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Leaverton, Anna H.

2. DATE AND HOUR OF DEATH

12-13-72

10:30p

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

Provident Hospital  
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE B. COUNTY

Maryland Baltimore

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐

NO ☒

E. STREET AND NUMBER

417 Meadow Road

5. SEX

Female

6. RACE

White

7. MARRIED ☐

NEVER MARRIED ☐

WIDOWED ☒

DIVORCED ☐

8. DATE OF BIRTH

12/10/99

9. AGE (in years last birthday)

73

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Cafeteria

10B. KIND OF BUSINESS OR INDUSTRY

Cafeteria Helper

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

William Holden

14. MOTHER'S MAIDEN NAME

Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service

No

16. SOCIAL SECURITY NO.

215-12-7425

17. INFORMANT

Granada Nursing Home

ADDRESS

Same

18.

412.2 147503  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Aspiration Pneumonia

DUE TO, OR AS A CONSEQUENCE OF:

Hypertensive Arteriosclerotic Cardiovascular Disease

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

4 hours

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

11/28/72

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

Pain

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

11 29 72

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☒

21F. HOW DID INJURY OCCUR?

Fall from bathroom

22. I certify that (I) (this hospital) attended the deceased from November 29 1972 to December 13 1972 that (I) (we) last saw the deceased alive on December 13 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

L. Pidlacan MD

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

12/13/72

23C. PHYSICIAN'S NAME (Type)

23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

12/16/72

24C. NAME OF CEMETERY or CREMATORY

Gardens Of Faith Cemetery

24D. LOCATION

Overlea

(City, town, or county)

Baltimore

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

DEC 18 1972

25B. NAME OF REGISTRAR

Sidney Johnston

25C. FUNERAL DIRECTOR

Lassahn Funeral Home 7401 Belair Rd. Balto.

ADDRESS

21236

FUNERAL DIRECTOR: IMPORTANT

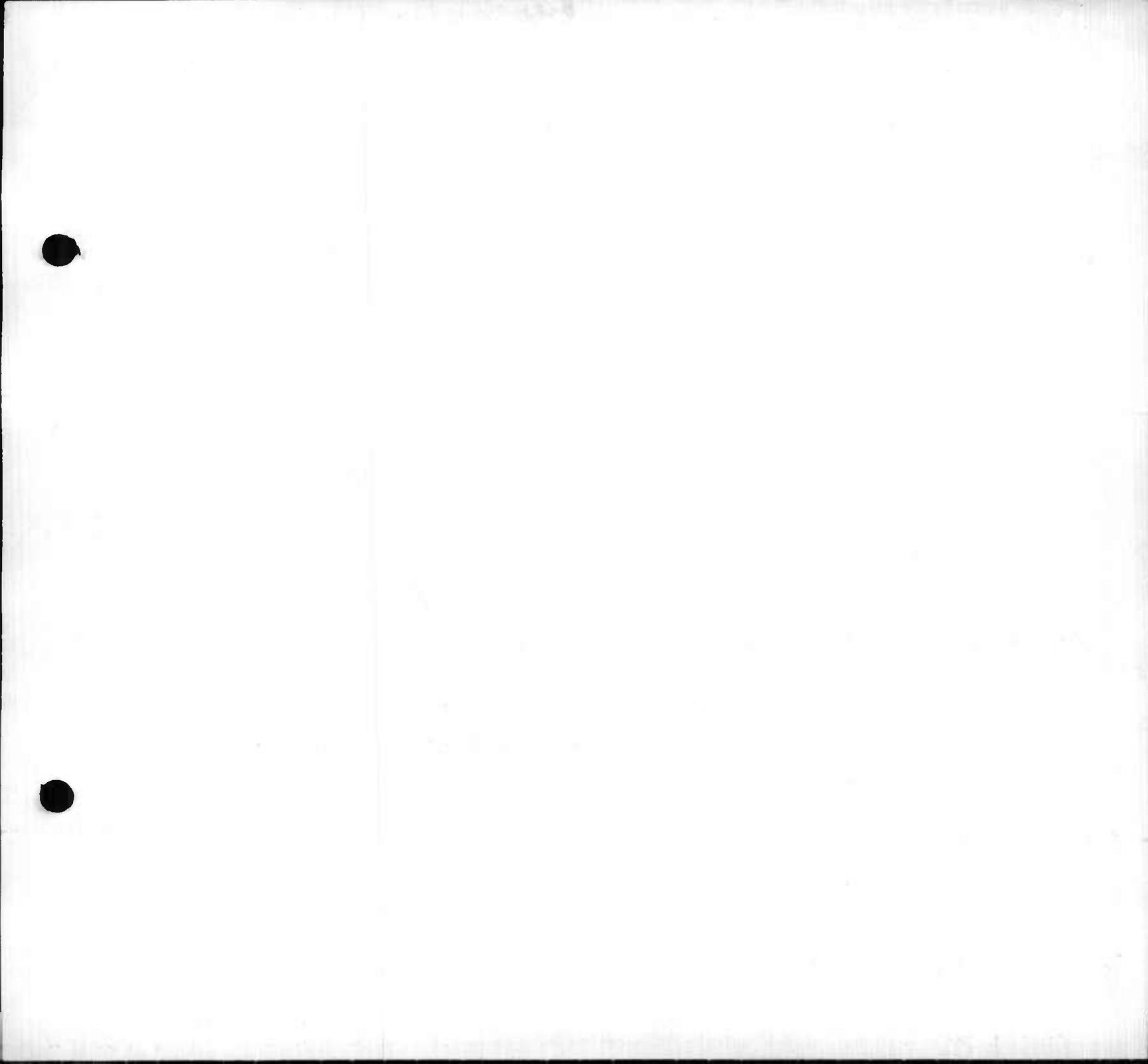
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 100-100-100

This image shows a blank, aged, cream-colored page, likely an endpaper or flyleaf from an old book. The paper has a slightly textured appearance with some minor discoloration and faint, illegible markings scattered across its surface. Two dark circular holes are visible on the left edge, suggesting it was once part of a bound volume. The overall tone is warm and vintage.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 11967		BALTIMORE CITY HEALTH DEPARTMENT		72 11967	
CERTIFICATE OF DEATH				REG. NO.	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>STANLEY J. KLIMAS</b>		2. DATE AND HOUR OF DEATH <b>Dec - 15 - 72 12 PM</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <b>43 SOUTH BALTIMORE GENERAL HOSPITAL</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <b>MARYLAND</b> B. COUNTY <b>2102</b>	
		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>1122 SARGENT ST. - 21223</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-2-02</b>	9. AGE (In years last birthday) <b>70</b>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Goal Shop</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Butcher Shop</b>		11. BIRTHPLACE (State or foreign country) <b>LITHUANIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JOSEPH Klimas</b>		14. MOTHER'S MAIDEN NAME <b>ANNA BYRIS</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>210-014518-A</b>		17. INFORMANT <b>Ruth H. Klimas 1122 Sargent St.</b>	
18. <b>162.1 I</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>BRONCHOGENIC CARCINOMA</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		<b>ASCVD.</b>			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (U) (this hospital) attended the deceased from <b>11-20</b> 19 <b>72</b> to <b>12-15</b> 19 <b>72</b> that (U) (we) last saw the deceased alive on <b>12-15</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (U) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>R. Tomasino M.D.</b>		23B. DATE SIGNED <b>Dec-15-72</b>		23C. PHYSICIAN'S NAME (Type) <b>RODOLFO TOMASINO M.D.</b>	
23D. ADDRESS <b>SOUTH BALT. GEN. HOSP.</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>12/18/72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Greenwood Home Ch.</b>		24D. LOCATION (City, town, or county) (State) <b>Dorsey, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 18 1972</b>	
25B. NAME OF REGISTRAR <b>Audrey Anderson</b>		25C. FUNERAL DIRECTOR <b>John J. Cowan, Son, Inc. 901 Haller St. Balt. Md.</b>		25D. ADDRESS	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 72 11968 STATE OF MARYLAND - DEPT. OF HEALTH	
BIRTH NO. 72 11968					
1. NAME OF DECEASED (Type or Print) <b>BOYER, ALBERT O.</b>		2. DATE AND HOUR OF DEATH <b>12/12/72 13:30 P. M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>LUTHERAN HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1602</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>46 LUTHERAN HOSPITAL</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>905 N. STRICKER ST.</b>					
5. SEX <b>MALE</b>	6. RACE <b>BLACK</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-6-16</b>	9. AGE (In years last birthday) <b>56</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABOR</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>					
13. FATHER'S NAME <b>CARLSON BOYER</b>		14. MOTHER'S MAIDEN NAME <b>MARY ELLEN JOHNSON</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES WWII</b>		16. SOCIAL SECURITY NO. <b>312-12-3686</b>		17. INFORMANT <b>MRS. ESSIE BOYER 905 N. STRICKER ST. BALTIMORE, MD.</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>DEHYDRATION - 3 weeks</b> MALNUTRITION - ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>PULMONARY TUBERCULOSIS undet.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12/12</b> 19 <b>72</b> to <b>12/12</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>12/12</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>R. S. Labog</b>		M.D. DEGREE <b>M.D.</b>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>RENATO A. LABOG, M.D.</b>		23D. ADDRESS <b>LUTHERAN HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BUR. A1</b>		24B. DATE <b>12/16/1972</b>		24C. NAME OF CEMETERY or CREMATORY	
24D. LOCATION (City, town, or county) (State)					
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 18 1972</b>		25B. NAME OF REGISTRAR <b>Sidney [Signature]</b>		25C. FUNERAL DIRECTOR <b>Kenneth Walley</b>	
ADDRESS <b>Chester, Md</b>					



1  
C-623

72 11969

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
STATE OF MARYLAND-DHMH

72 11969

BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) Clara Mae Christopher		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 12 14 72 8:35 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1212 Wilcox Street		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 14 72 8:35 P. M.	
6. SEX Female		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1001	
9. DATE OF BIRTH 8-30-1900		10. AGE (in years lost birthday) 72	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ***** VanSkiven		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker	
15. MOTHER'S MAIDEN NAME *****		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 217-18-4078		18. INFORMANT Robert Blick 625 N. Rose Street	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE William P. Mulloy, M.D. EXAMINER'S NAME (Type) 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 12-18-72 24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland 25A. DATE REC'D BY HEALTH DEPT. DEC 18 1972 25B. NAME OF REGISTRAR Sidney H. Weston 25C. FUNERAL DIRECTOR 1211 Chesaco Avenue			

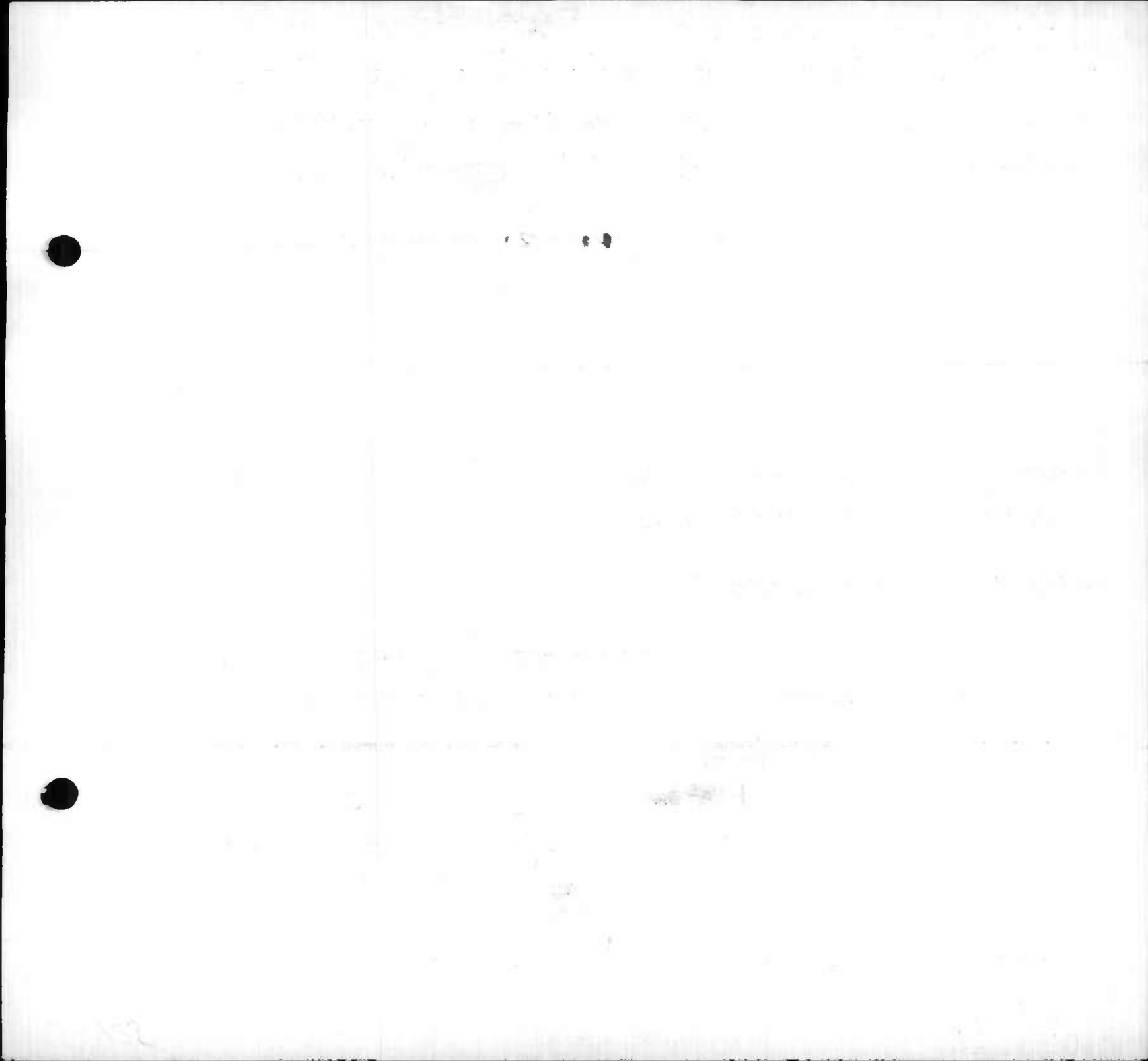


*[Faint, illegible text, likely bleed-through from the reverse side of the page]*

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
1. NAME OF DECEASED (Type or Print)		72 11970		72 11970	
2. DATE AND HOUR OF DEATH		CERTIFICATE OF DEATH		STATE OF MARYLAND-DHMH	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		5. DATE OF DEATH	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY		12-14-72 12:40 M.	
90 Bolton Hill Nursing 1400 John Street		MD - BALTO -		2833	
6. CITY OR TOWN		D. INSIDE CITY LIMITS?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER		5313 Windsor Mills RD			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
F	C	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	4-7-1900	72	U. S. A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Sales Lady - Hecht May Company				Waynesboro, Pennsylvania	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
John McCarney		Charlotte (?)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No None		217-18-8252 A		ADMINISTRATIVE	
18. 199.0 I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE		12/12/72	
[This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.]		DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) metastatic carcinoma ??		1 year	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) arteriosclerosis		year	
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 3-30 1973 to 12-14-72 that (I) (we) lost saw the deceased alive on 12-14-72 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
almond		12/14/72			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
ALAN H. M. RECHT MD		25 Pearl St Balto and your			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		12/16/1972		MEADOWRIDGE MEMORIAL PARK	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
DEC 18 1972		LORING BYERS		8728 Liberty Road ADDRESS 21133	
VS 150-REV. 1/1/68				LORING BYERS FUNERAL DIRECTORS, P. A.	

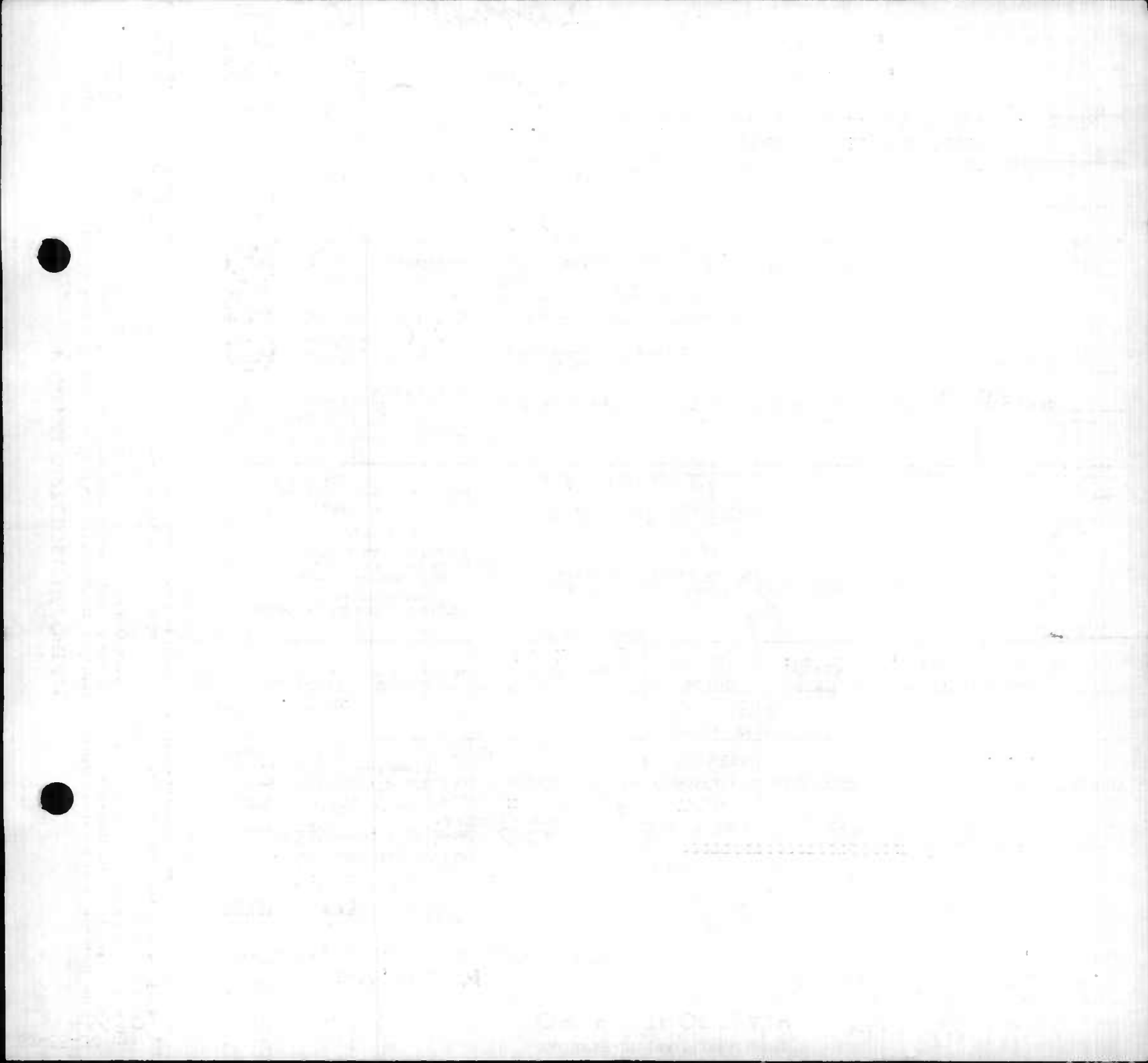


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CITY OF BALTIMORE  
Baltimore City Health Department  
CERTIFICATE OF DEATH

REG. NO. 72 11971  
STATE OF MARYLAND DEPT. HEALTH

BIRTH NO. 72 11971		1. NAME OF DECEASED (Type or Print) Belt, Ruth M		2. DATE AND HOUR OF DEATH 12/12/72 10:23 p. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland B. COUNTY 1307			
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female		6. RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 7/14/06		9. AGE (In years last birthday) 66		10. UNDER 1 Yr. Months Days 11. UNDER 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Worker		10B. KIND OF BUSINESS OR INDUSTRY Department Store		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James F. Myers		14. MOTHER'S MAIDEN NAME Kate Stump	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216 18 9445		17. INFORMANT 4940 Eastern Avenue ADDRESS BCH RECORDS: Baltimore, Maryland 21224	
18. 200.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Renal Failure (B) Septic Shock (C) Retinulum cell Sarcoma Treatment		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days 10 days 5 months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-28-1972 to 12-12-1972 that (I) (we) last saw the deceased alive on 12-12-1972 and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Walter W Malloy M.D.				23B. DATE SIGNED 12-12-72	
23C. PHYSICIAN'S NAME (Type) Walter Malloy M.D.		23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Md. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 16 Dec 72		24C. NAME of CEMETERY or CREMATORY Druid Ridge Cemetery	
24D. LOCATION Pikesville, Blato Co Maryland		25A. DATE REC'D BY HEALTH DEPT. DEC 18 1972			
25B. NAME OF REGISTRAR Sidney [Signature]		25C. FUNERAL DIRECTOR Burgess Funeral Home, Baltimore Maryland			



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 11972</u>	
BIRTH NO. <u>72 11972</u>				STATE OF <del>MARYLAND</del> <u>DEMD</u>	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
<u>LENA WINSHIP</u>			<u>DEC 12, 1972</u>   <u>4:30 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE <u>MD</u> B. COUNTY <u>1306</u>		
<u>44 Union Mem. Hosp.</u>			C. CITY OR TOWN <u>BALTO.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>F</u> 6. RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>02-22-97</u> 9. AGE (In years last birthday) <u>75</u>		10. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>			11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>JARROD BISH</u>			14. MOTHER'S MAIDEN NAME <u>CORA ANTHONY</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>212-20-3434</u>		17. INFORMANT ADDRESS <u>Marie Donati 233 Colgate Av 21222</u>
18. <u>154.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  <u>RECURRENT CD OF RECTUM</u> (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		
19A. DATE OF OPERATION <u>2</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that <del>(he)</del> (this hospital) attended the deceased from <u>11/27</u> 19 <u>72</u> to <u>12/12</u> 19 <u>72</u> , that (I) <del>(we)</del> last saw the deceased alive on <u>12/12</u> 19 <u>72</u> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(We)</del> (did) <del>(did not)</del> view the body after death.					
23A. SIGNATURE <u>[Signature]</u> <u>MD</u>			23B. DATE SIGNED <u>Dec 12, 1972</u>		23C. PHYSICIAN'S NAME (Type) <u>R. CARNEIRO, MD</u>
23D. ADDRESS <u>33rd &amp; CALVERT STS</u>			24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		
24B. DATE <u>12/15/72</u>			24C. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 18 1972</u>			25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR ADDRESS <u>430 Ridge Funeral Home, Balto. Md</u>

1803 Oct 10 (17) 1803

1803 Oct 10 (17) 1803

1803 Oct 10 (17) 1803

1803 Oct 10 (17) 1803

1803 Oct 10 (17) 1803

1803 Oct 10 (17) 1803

1803 Oct 10 (17) 1803

1803 Oct 10 (17) 1803

1803 Oct 10 (17) 1803

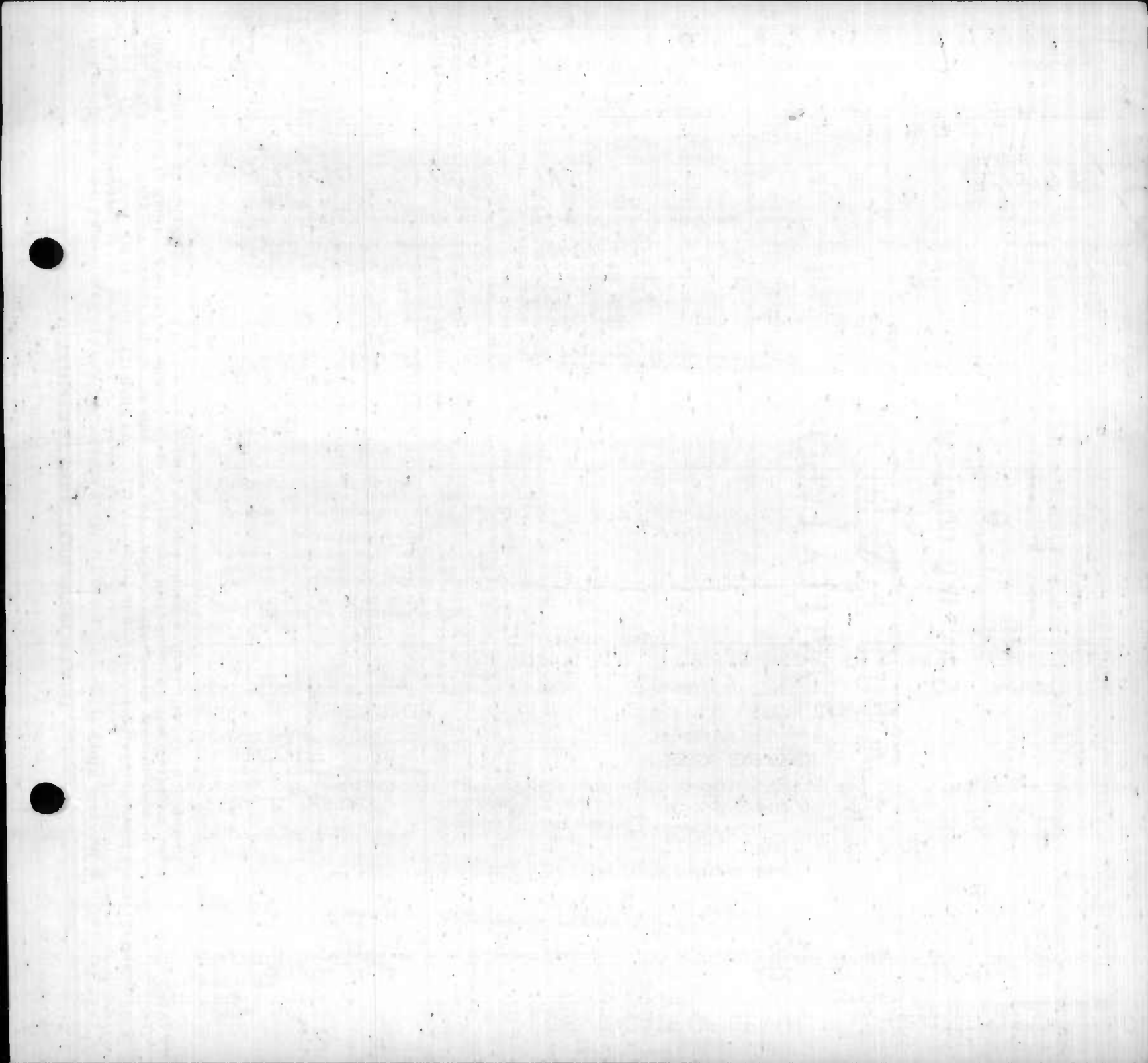
1803 Oct 10 (17) 1803



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

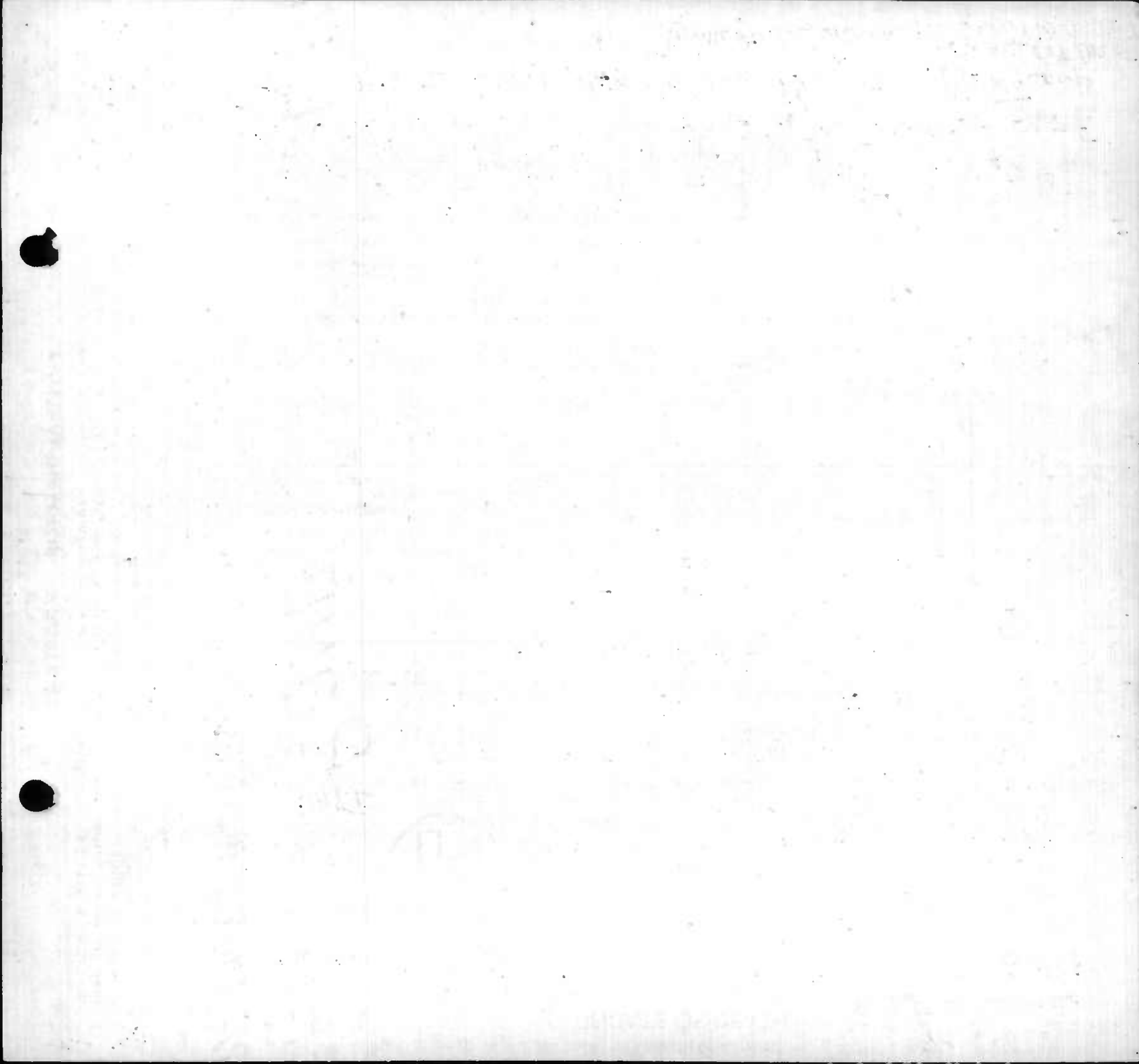
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 11973</u>	
72 11973				STATE OF MARYLAND-DEME	
BIRTH NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>MABEL QUICKLEY</u>			2. DATE AND HOUR OF DEATH <u>XXX 12:15am 12/14/72</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>THE JOHNS HOPKINS HOSPITAL</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> CITY <u>BALTIMORE</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1524 DRUID HILL AVE.</u>		
5. SEX <u>FEMALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-14-1890</u>	9. AGE (In years last birthday) <u>82</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>SAVA JOHNSON</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>HOWARD SMITH</u>			14. MOTHER'S MAIDEN NAME <u>SARAH JOHNSON</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>219-30-8421</u>	17. INFORMANT ADDRESS <u>CHARLES SMITH - 63 CORNWALL AVE-BUFFALOE, N.Y.</u>		
18. <u>444.21</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Infarct in of Small Bowel</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Arteriosclerotic Vascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2 None</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12/13</u> 19 <u>72</u> to <u>12/13</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>12/13</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Stephen T. Miller MD</u> DEGREE				23B. DATE SIGNED <u>12/13/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>STEPHEN T. MILLER, MD.</u> DEGREE				23D. ADDRESS <u>THE JOHNS HOPKINS HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>12-18-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>CEDAR HILL CEMETERY</u>	
24D. LOCATION (City, town, or county) (State) <u>A A CO.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 18 1972</u>			
25B. NAME OF REGISTRAR <u>Andrew S. Phillips</u>		25C. FUNERAL DIRECTOR ADDRESS <u>ABINGTON S. PHILLIPS-1721-27 N. MONROE ST</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 72 11974		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 11974	
1. NAME OF DECEASED (Type or Print) <b>TWEEDY HELEN G</b>		2. DATE AND HOUR OF DEATH <b>12-13-72 11:00 AM</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>90 Caton Manor Convalescent Center</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>BALTO</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1708 Bitten House Ave.</b>			
5. SEX <b>F</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-31-11</b>	9. AGE (In years last birthday) <b>61 yrs</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>OFFICE WORK</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>DEPT. STORE</b>		11. BIRTHPLACE (State or foreign country) <b>Kansas</b>	
13. FATHER'S NAME <b>Joseph Lournan</b>		14. MOTHER'S MAIDEN NAME <b>Freda Kriebel</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>512-10-6460</b>		17. INFORMANT <b>Shirley Sullivan</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>194.0 I</b> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>19A. DATE OF OPERATION</b> <b>0</b> <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <b>20A. AUTOPSY? (Yes or No)</b> <b>No</b> <b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>		CAUSE OF DEATH <b>(A) IMMEDIATE CAUSE</b> <b>Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF: <b>(B) Ca 2 Adrenal</b> DUE TO, OR AS A CONSEQUENCE OF: <b>(C)</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>?</b> <b>?</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <b>HE</b> (this hospital) attended the deceased from <b>11-17 1972</b> to <b>12-13 1972</b> , that (I) <b>We</b> last saw the deceased alive on <b>12-13 1972</b> and that in (my) <b>own</b> opinion death occurred on the date and hour and from the causes stated above. (I) <b>We</b> (did) (did not) view the body after death.					
23A. SIGNATURE <b>W. K. Gallager Jr. M.D.</b>		23B. DATE SIGNED <b>12/13/72</b>		23C. PHYSICIAN'S NAME (Type) <b>W. K. Gallager Jr. M.D.</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>12-13-72</b>		24B. DATE <b>12-13-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>UOFM ANATOMY BOARD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>12-18-1972</b>		25B. NAME OF REGISTRAR <b>Raymond D. Curran</b>		25C. FUNERAL DIRECTOR <b>8125 CARLETT DR. TOWSON, MD. 21204</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 11975	
BIRTH NO. 72 11975				STATE OF MARYLAND - DHH	
1. NAME OF DECEASED (Type or Print) ROBERT WHITE			2. DATE AND HOUR OF DEATH 12/13/72 3:29 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) THE JOHNS HOPKINS HOSPITAL 33			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 1001 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1003 E. PRESTON ST.		
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-5-29	9. AGE (In years last birthday) 43	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md	
13. FATHER'S NAME THADDEUS WHITE			14. MOTHER'S MAIDEN NAME IOLA HUNT		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-22-8547		17. INFORMANT Eugene Stewart	
18. 303.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 2 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) YES 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from NOVEMBER 27 19 72 to DECEMBER 13 19 72, that (I) (we) last saw the deceased alive on DECEMBER 13 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE Frederick L. Ferris Jr. MD 23B. DATE SIGNED 12/13/72 23C. PHYSICIAN'S NAME (Type) FREDERICK L. FERRIS JR. MD 23D. ADDRESS DHH 601 N. BROADWAY 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 12/18/72 24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary 24D. LOCATION (City, town, or county) (State) A. A. County - Md. 25A. DATE REC'D BY HEALTH DEPT. DEC 18 1972 25B. NAME OF REGISTRAR Sidney Johnston 25C. FUNERAL DIRECTOR Joseph J. Lock 25D. ADDRESS 13041 Central Ave					

97705

END FILE

PE

1



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>72 11976</u> STATE OF MARYLAND-DHMH	
BIRTH NO. <u>72 11976</u>				2. DATE AND HOUR OF DEATH <u>12/15/72</u> <u>4:10 PM</u> M.			
1. NAME OF DECEASED (Type or Print) <u>DOWNES, EMMA</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>--</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>ST. AGNES Hosp.</u>				C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>FEMALE</u> 6. RACE <u>NEGRO</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>3 11 01</u>		9. AGE (In years last birthday) <u>71</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>?</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>ST AGNES HOSPITAL-BALTO., MD.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>250.9 I</u> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  19A. DATE OF OPERATION <u>0</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  20A. AUTOPSY? (Yes or No) <u>NO</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Cardio-respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Pulmonary Edema on the basis of ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Diabetes Mellitus</u>  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>12/15</u> 19 <u>72</u> to <u>12/15</u> 19 <u>72</u> , that <input checked="" type="checkbox"/> (I) (we) last saw the deceased alive on <u>12/15</u> 19 <u>72</u> and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.							
23A. SIGNATURE <u>S. N. Moussavian, M.D.</u>				23B. DATE SIGNED <u>12/15/72</u>		23C. PHYSICIAN'S NAME (Type) <u>SEYED MOUSSAVIAN, M.D.</u>	
23D. ADDRESS <u>ST AGNES HOSPITAL-BALTO., MD.</u>							
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/20/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Balto. National Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>5501 Frederick St. Balto. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 18 1972</u>		25B. NAME OF REGISTRAR <u>Sidney [illegible]</u>		25C. FUNERAL DIRECTOR <u>Joseph [illegible]</u>		ADDRESS <u>13041 [illegible]</u>	



SEALD HOSBIAH' W.O.

SI YEMEZ HOSBIAH' W.O.

2. H. HOSBIAH' W.O.

13/12/12

X XXXX

13/12

5

XXX

13/12

1

13/12

X

XX

BU

SI YEMEZ HOSBIAH' W.O.

WORE

WORE

WORE

WORE

3 11 01

11

330 HIKKENS VAL - (OYLOH WARE ASS WAT)

WORE

WORE

WORE

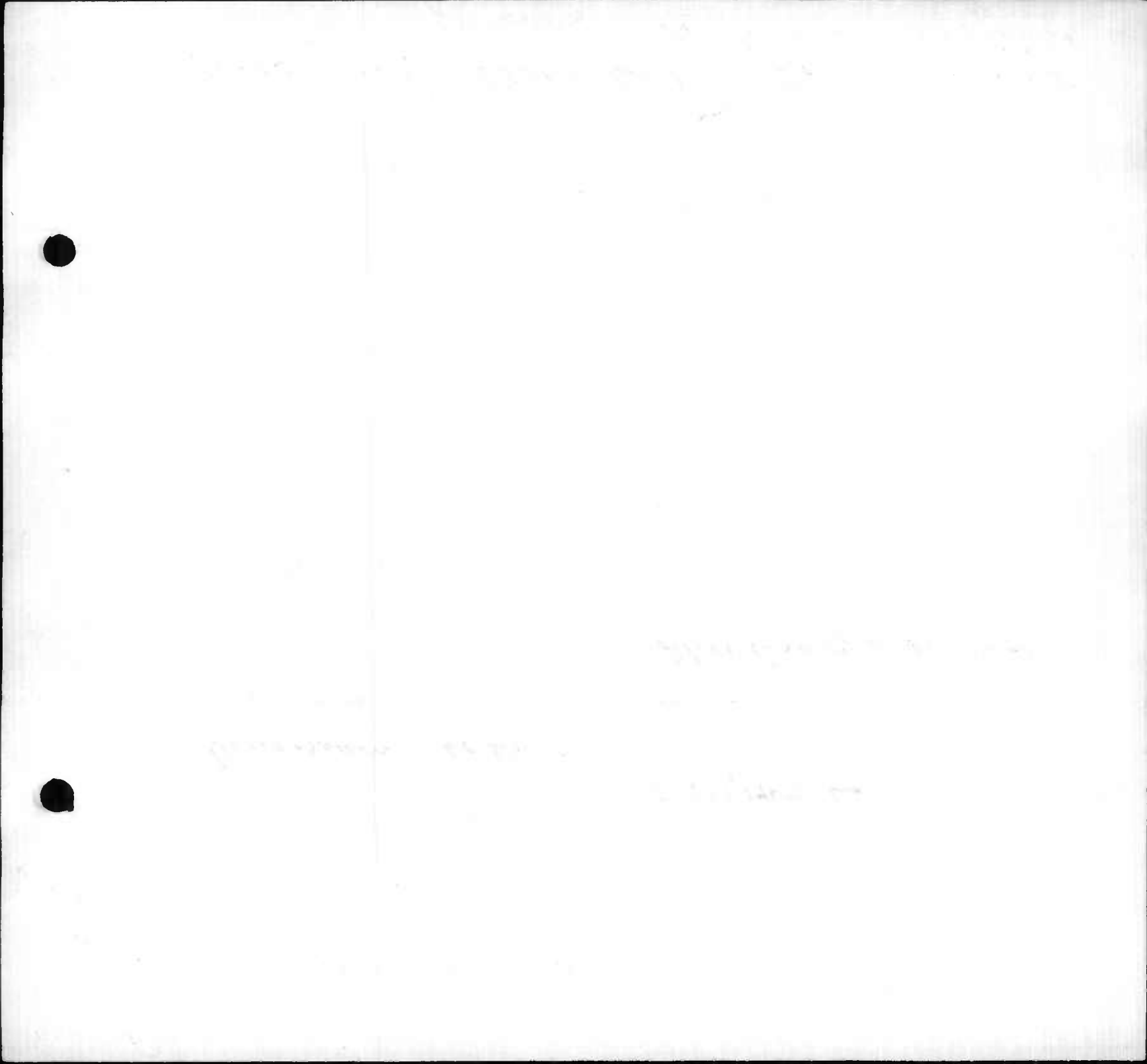
WORE

13/12/12

13/12/12

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		72 11977	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		STATE OF MARYLAND - DISTRICT	
Ward, Dorothy MABEL		12/16/72 18:35 AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 34 Bon Secours Hospital		A. STATE Maryland		B. COUNTY 2001	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 114 N. Payson St.			
5. SEX Female	6. RACE Black	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 08/31/1909	9. AGE (in years last birthday) 63	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Steven Edmonds		14. MOTHER'S MAIDEN NAME Elizabeth millner		12. CITIZEN OF WHAT COUNTRY? U.S.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-74-9688		17. INFORMANT Alice Canoy 114 N Payson St	
18. 153.01 CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary Edema		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Adenocarcinoma of Cecum			
(B) _____		DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-16-1972 to 12-16-1972 that (I) (we) last saw the deceased alive on 12-16-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Abedi, M.D.		23B. DATE SIGNED 12-16-72		23C. PHYSICIAN'S NAME (Type) ABEDI, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 12/20/72		24C. NAME OF CEMETERY or CREMATORY Cedar Hill	
24D. LOCATION (City, town, or county) (State) Baltimore MD 21225		25A. DATE REC'D BY HEALTH DEPT. DEC 18 1972		25B. NAME OF REGISTRAR Sidney Johnson	
25C. FUNERAL DIRECTOR Warren D. Hays		25D. ADDRESS 636 N. G. St.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 11978		REG. NO. 72 11978	
CERTIFICATE OF DEATH				STATE OF MARYLAND-DEMD	
BIRTH NO. 72 11978		1. NAME OF DECEASED (Type or Print) <b>NORA E. LANCIONE</b>		2. DATE AND HOUR OF DEATH <b>DEC. 15th. 1972 8.30 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>402 S. HIGH ST.</b>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTO.</b>		C. CITY OR TOWN <b>BALTO.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>F.</b> 6. RACE <b>W.</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/14/83</b> 9. AGE (In years last birthday) <b>89</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STOREKEEPER</b>	
11. BIRTHPLACE (State or foreign country) <b>ITALY</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>PHILIP DE CEASARE</b>	
14. MOTHER'S MAIDEN NAME <b>LIBORIA ?.</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <b>NO</b> 16. SOCIAL SECURITY NO. <b>218-36-5863A</b>		17. INFORMANT <b>MRS. JOSEPHINE SANTORO</b> ADDRESS <b>402 S. HIGH ST.</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Acute Myocardial Infarction</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>CHD</b> <b>C. V. D.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>one week</b> <b>10 y</b> <b>2 y</b>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
19A. DATE OF OPERATION <b>0</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4/1</b> 19 <b>71</b> to <b>12/15</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>12/13</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>S. C. Feldman</b>		23B. DATE SIGNED <b>12/16/72</b>		23C. PHYSICIAN'S NAME (Type) <b>S. C. FELDMAN S. C. Feldman</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12/19/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>HOLY REDEEMER BELAIR RD AT MORAVIA AVE. BALTO MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 18 1972</b>		25B. NAME OF REGISTRAR <b>Adrienne W. H. H. H.</b>		25C. FUNERAL DIRECTOR <b>Adrienne W. H. H. H.</b> ADDRESS <b>322 S. HIGH ST.</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
72 11979				72 11979	
CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Dominic M. Minenta		12/14/72 8:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					
12-27-72 Dominic M. Minenta					
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)					
A. STATE B. COUNTY					
Baltimore 302					
5. CITY OR TOWN					
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
E. STREET AND NUMBER					
244 S. Exeter St.					
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. UNDER 1 Yr. Months: Days
M. W.		WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8/10/28	44	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		
BARTENDER			BALTO Md.		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY?		
BAR.			U.S.A.		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Rocco Minenta			Catherine Palmisano		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
YES. W.W. II			217-24-0033		
17. INFORMANT			ADDRESS		
MRS. MARY WILLIAMS 1006 STILES ST.					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
			Cardiorespiratory Arrest		
ANTECEDENT CAUSES			(B) DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(C) Branchogenic Carinoma					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 11-30 1972 to 12-14 1972, that (I) (we) last saw the deceased alive on 12-14 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
[Signature]				Dec 14, 1972	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		12/18/72		HOLY REDEEMER, BELAIR RD AT MORAVIA AVE. BALTO. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
DEC 18 1972		[Signature]		[Signature]	
25D. ADDRESS					
322 S. HIGH ST.					

12-27-1972 - Affidavit of Wife, Mrs. Geraldine C. Minento.

Marriage License #9923, City of Baltimore, State of Maryland of Dominic M. Minento & Geraldine C. Lewis, married August 25, 1962 (Rodney A. Gatzke, Minister ).

Record search certificate from Circuit Court of Balto. City, Md. discloses no application for divorce on behalf of either Dominic M. Minento or Geraldine C. Minento - examined from January-1950 to December 26, 1972 - Dated Dec. 26, 1972.

Record search certificate from Circuit Court No. 2 of Balto. City, Md. discloses no application for divorce on behalf of either Dominic M. Minento or Geraldine C. Minento - examined from January-1947 to December 26, 1972 - Dated Dec. 26, 1972.

hs



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 72 11980		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 11980	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) FLORENCE VIRGINIA JENKINS			2. DATE AND HOUR OF DEATH DEC 16, 1972 9:00 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD CHURCH HOME & HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MARYLAND B. COUNTY 2664		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 35			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX F			6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 12-8-1896			9. AGE (In years last birthday) 76		10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Practical Nurse			10B. KIND OF BUSINESS OR INDUSTRY Practical Nursing		11. BIRTHPLACE (State or foreign country) Edcott, Cal. Edward G. MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME GEORGE DOLLARD		
14. MOTHER'S MAIDEN NAME EMMA GAVIGAN			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 207-071275			17. INFORMANT ANDREW P. REDYK ADDRESS 2601 FAIR AVE - BALTO MD 21224		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 410.91 317-07-1075 CAUSE OF DEATH MYOCARDIAL INFARCTION			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: MYOCARDIAL INFARCTION		
(B) ARTERIOSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF:			(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). INTEST. OBSTRUCTION 2° to ADHESIVE BANDS					
19A. DATE OF OPERATION 12-11-72			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED INTEST. OBSTRUCTION		20A. AUTOPSY? (Yes or No) NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 12-9 1972 to 12-16 1972 that (I) (we) last saw the deceased alive on 12-16 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE C. H. H. H.			23B. DATE SIGNED 12-16-72		23C. PHYSICIAN'S NAME (Type) CEAR P. H. H.
23D. ADDRESS CHURCH HOME & HOSPITAL					
24A. BURIAL CREMATION REMOVAL (Specify) BURIAL			24B. DATE Dec 17 1972		24C. NAME OF CEMETERY OR CREMATORY Green Haven Cemetery
24D. LOCATION (City, town, or county) Blen Burnie, Md.			24E. LOCATION (City, town, or county) Blen Burnie, Md.		
25A. DATE REC'D BY HEALTH DEPT. DEC 18 1972			25B. NAME OF REGISTRAR Audrey H. H.		25C. FUNERAL DIRECTOR CURTIS E. EVANS ADDRESS 1400 S. CHASE ST - 21230

100% 3/20/00  
100%

100% 3/20/00

100% 3/20/00

100% 3/20/00

100% 3/20/00

100% 3/20/00

100% 3/20/00

100% 3/20/00

100% 3/20/00

100% 3/20/00

100% 3/20/00

100% 3/20/00

100% 3/20/00

100% 3/20/00

100% 3/20/00

100% 3/20/00

100% 3/20/00

100% 3/20/00

72 11981

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 11981

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print)		ROBERT JOHNSON		2. DATE OF DEATH		Known <input type="checkbox"/> Month Day Year Hour		Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD		Month Day Year Hour		M.	
FULL NAME OF HOSPITAL OR INSTITUTION		00 2717 W. Garrison Ave.		5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE		B. COUNTY	
6. SEX		7. RACE		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
male		negro		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH		10. AGE (In years last birthday)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF		13. FATHER'S NAME	
8-20-22		50		Maryland		U.S.A.		John H. Johnson	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
				Sarah Manning		yes War I		219-16908	
18. INFORMANT		ADDRESS		19. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Alma Arvin		2717 W Garrison Ave		Arteriosclerotic cardiovascular disease					
				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
				(B) DUE TO, OR AS A CONSEQUENCE OF:					
				(C) DUE TO, OR AS A CONSEQUENCE OF:					
				II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Fatty metamorphosis of liver			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No)		yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED		22F. HOW DID INJURY OCCUR?					
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>							
23.		I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED			
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		Ronald N. Kornblum, M.D.		12-11-72			
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		12-14-72		Arbutus Memorial Park		Balto Md			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
DEC 18 1972		Sidney Johnston		Rayner Sanders		217 E. Preston St			

Handwritten text at the top of the page, possibly a title or header, including the word "REPORT".

Main body of handwritten text, organized into several paragraphs across the page.

Handwritten text at the bottom of the page, possibly a signature or footer.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

REG. NO. 72 11982  
STATE OF MARYLAND-DMCH

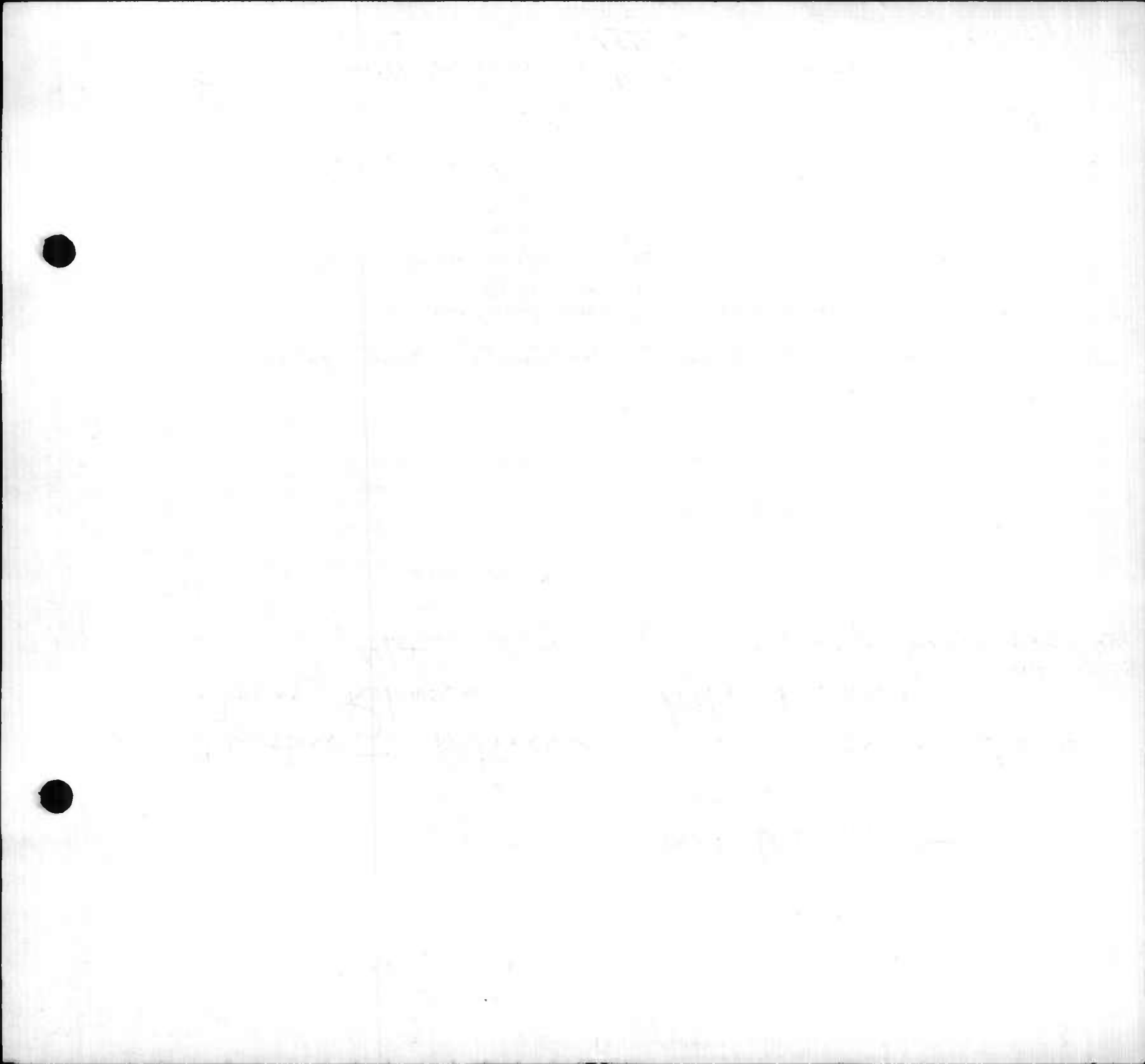
BIRTH NO. <u>72 11982</u>		1. NAME OF DECEASED (Type or Print) <u>ROBERT K. MATHERLY</u>		2. DATE AND HOUR OF DEATH <u>12.15.1972</u> <u>10:00 a.m.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>CHURCH HOME AND HOSPITAL</u> FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>35</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md</u> B. COUNTY <u>201</u>		
5. SEX <u>MALE</u> 6. RACE <u>WHITE</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>9.5.1907</u> 9. AGE (In years last birthday) <u>65 yrs</u>		10. UNDER 1 Yr. Months Days 11. UNDER 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LANDSCAPER</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>WOODLAWN CEMETERY</u>		11. BIRTHPLACE (State or foreign country) <u>MA. FLOYD, VA.</u>
12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u>			13. FATHER'S NAME <u>WILLIAM MATHERLY</u>		
14. MOTHER'S MAIDEN NAME <u>PARTHENA BUCKNER</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		
16. SOCIAL SECURITY NO. <u>231 03 6087</u>			17. INFORMANT <u>CANIOUS L MATHERLY 2029 E BALTIMORE ST.</u>		
18. <u>436.91</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>(A) IMMEDIATE CAUSE Cerebral vascular accident</u> <u>DUE TO, OR AS A CONSEQUENCE OF:</u> <u>(B) _____</u> <u>(C) _____</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>~ 14 days</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>12.1.1972</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Block @ communicating artery</u>		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If only medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <u>11.25.1972</u> to <u>12.15.1972</u> that (I) (we) last saw the deceased alive on <u>12.15.1972</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Had. Hakk</u>		23B. DATE SIGNED <u>12.15.1972</u>		23C. PHYSICIAN'S NAME (Type) <u>A-HADI I. HAKKI M.D.</u>	
23D. ADDRESS <u>CHURCH HOME AND HOSPITAL BALTIMORE, MARYLAND 21231</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>			
24B. DATE <u>DEC 19-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>HOLLY HILL MEMORIAL GARDENS</u>		24D. LOCATION (City, town, or county) (State) <u>217 OLD CREMS RD BALTO, MD</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 18 1972</u>		25B. NAME OF REGISTRAR <u>Andrew W. H. H. H.</u>		25C. FUNERAL DIRECTOR <u>DUPPEL BROS INC 1800 E LOMBARD ST</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 11983		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 11983	
BIRTH NO.		1. NAME OF DECEASED OF MARYLAND DEPT (Type or Print) <b>FRANK L. ROBINSON</b>		2. DATE AND HOUR OF DEATH <b>12/14/72 1pm</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTO.</b>		C. CITY OR TOWN <b>BALTO.</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>99 Harbor View Nursing Home</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <b>2539 - McCulloh St.</b>	
5. SEX <b>M</b>	6. RACE <b>B</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-28-90</b>	9. AGE (In years last birthday) <b>82</b>	10. IF Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffeur</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland, Balto</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>James Robinson</b>		14. MOTHER'S MAIDEN NAME <b>Lottie Robinson</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>N/A</b>		16. SOCIAL SECURITY NO. <b>217011318</b>		17. INFORMANT <b>Chart Evelyn Henson</b>	
18. <b>43391</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <b>Left Embolic CVA</b>		<b>6/1/1972</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>Multiple Cardiovascular Accidents</b>		<b>Years</b>	
(C)					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <b>July 25</b> 19 <b>72</b> to <b>December 14</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>December 14</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Peter H. Rheinstein, M.D.</b>		23B. DATE SIGNED <b>14 December 1972</b>		23C. PHYSICIAN'S NAME (Type) <b>PETER H. RHEINSTEIN, MD</b>	
23D. ADDRESS <b>HARBOR VIEW NURSING HOME</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-19-72</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO, MD</b>		25A. DATE REC'D BY HEALTH DEPT <b>DEC 18 1972</b>	
25B. NAME OF REGISTRAR <b>Edw. H. Heston</b>		25C. FUNERAL DIRECTOR <b>Edw. H. Heston</b>		ADDRESS <b>1701 Harview St</b>	





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 11984</u>	
72 11984				CERTIFICATE OF DEATH	
BIRTH NO. <u>72 11984</u>			STATE OF <u>MARYLAND-DHMH</u>		
1. NAME OF DECEASED (Type or Print) <u>Freeman, Henrietta Gunn</u>			2. DATE AND HOUR OF DEATH <u>December 14, 1972</u> <u>7:30 p.</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <u>39</u> <u>Provident Hospital, Inc.</u> <u>2600 Liberty Height Ave.</u> <u>Baltimore, Md. 21215</u>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1512</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3738 Reisterstown Rd.</u>		
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>7-8-32</u>	9. AGE (In years last birthday) <u>40</u>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>n/a</u>		
11. BIRTHPLACE (State or foreign country) <u>Alabama, CHILTON CO.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>T. S. Gunn</u>			14. MOTHER'S MAIDEN NAME <u>Lillie Mae Williams</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>420-24-0106</u>		
17. INFORMANT <u>Lillie M. Gunn (MOTHER)</u>			ADDRESS <u>106 13th St. Alabama</u>		
18. <u>571.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH <u>Bleeding esophageal varices</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cirrhosis of liver</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
19. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Aspiration pneumonia</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At <input type="checkbox"/> Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>December 13,</u> 19 <u>72</u> to <u>December 14,</u> 19 <u>72</u> , that (I) (we) last saw the deceased alive on <u>December 14,</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>V. Chitaplee MD</u>			23B. DATE SIGNED <u>Dec. 15, 72</u>		23C. PHYSICIAN'S NAME (Type) <u>V. Chitaplee</u>
23D. ADDRESS <u>Provident Hosp.</u>			23E. DATE REC'D BY HEALTH DEPT. <u>DEC 18 1972</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>12/18/72</u>			24B. DATE <u>12/18/72</u>		
24C. NAME OF CEMETERY OR CREMATORY <u>Salem Cemetery</u>			24D. LOCATION (City, town, or county) (State) <u>Chilton Co., Alabama</u>		
25A. NAME OF REGISTRAR <u>Sidney M. Horton</u>			25B. FUNERAL DIRECTOR <u>MORTON &amp; DYETT FUNERAL HOME</u>		
25C. ADDRESS <u>1701 Laurens</u>			25D. ADDRESS <u>Baltimore, Md. 21217</u>		

THE UNIVERSITY OF CHICAGO  
LIBRARY

1900

1900

1900

THE UNIVERSITY OF CHICAGO

1900

1900

THE UNIVERSITY OF CHICAGO  
LIBRARY

1900

1900

1900

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>72 11985</u>	
BIRTH NO. <u>72 11985</u>		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>MR WILEY ANTHONY</u>		2. DATE AND HOUR OF DEATH <u>01:50 AM 12-17-72</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>2002</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>BON SECOURS HOSPITAL</u>		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>M</u> 6. RACE <u>B</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-25-89</u> 9. AGE (in years last birthday) <u>83</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	
11. BIRTHPLACE (State or foreign country) <u>N. C. Halifax</u>		12. CITIZEN OF WHAT COUNTRY? <u>U-S-A</u>	
13. FATHER'S NAME <u>HOLMER ANTHONY</u>		14. MOTHER'S MAIDEN NAME <u>Phillip, Sarah</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>N/A</u>		16. SOCIAL SECURITY NO. <u>242-14-4256</u>	
17. INFORMANT <u>Minnie Anthony</u>		ADDRESS <u>2856 W. Mulberry St.</u>	
18. <u>412.41</u> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE <u>Broncho-Pneumonia</u>	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES		(B) <u>Chronic obstructive pulmonary disease</u>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO, OR AS A CONSEQUENCE OF:	
(C) <u>APC V D +</u>			
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>2:30 PM December 16, 1972</u> to <u>0:50 AM 12-17-72</u> that (I) (we) last saw the deceased alive on <u>0:50 AM 12-17-72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>A. Daberi, M.D.</u>		23B. DATE SIGNED <u>12-17-72</u>	
23C. PHYSICIAN'S NAME (Type) <u>ABAND DABERI-GHOUGHAN</u>		23D. ADDRESS <u>Bon Secours Hospital Balto. MD 21223</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-21-72</u>	
24C. NAME OF CEMETERY or CREMATORY <u>Carver Mem Pk.</u>		24D. LOCATION (City, town, or county) (State) <u>Laurel, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 18 1972</u>		25B. NAME OF REGISTRAR <u>Dr. J. H. Dyett</u>	
25C. FUNERAL DIRECTOR <u>1601-1101-1101-1101</u>		25D. ADDRESS <u>1601-1101-1101-1101</u>	

Handwritten text at the top of the page, possibly a title or header.

Main body of handwritten text, consisting of several paragraphs. The handwriting is cursive and somewhat faded.

Handwritten text at the bottom of the page, possibly a conclusion or signature block.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death was: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-436

72-11986

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 72-11986

BIRTH NO. STATE OF MARYLAND-DMH

1. NAME OF DECEASED  
(Type or Print)

FELDER, William

(FELLER) F-460

2. DATE AND HOUR OF DEATH

12/13/72

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Lutheran Hospital of Md.

46

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE B. COUNTY

Md.

C. CITY OR TOWN

Baltimore 21216

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

3010 Brighton St.

5. SEX

M

6. RACE

BLACK

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

8/15/14

9. AGE (In years  
last birthday)

58

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Manning, S. C.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

WILLIAM FELDER

14. MOTHER'S MAIDEN NAME

MARY FELDER

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

217050737

17. INFORMANT

Mary Felder

ADDRESS

SAME

18.

162.1 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Ca of lung.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Tracheo-esophageal Fistula

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐

Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_,  
that (I) (we) last saw the deceased alive on \_\_\_\_\_ 19\_\_\_\_ and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

*[Signature]*

DEGREE

Attending  
Phys. ☐

Med.  
Director ☐

Staff  
Phys. ☒

23B. DATE SIGNED

1-15-72

23C. PHYSICIAN'S  
NAME (Type)

Dr. M. ALI-NAFICY

DEGREE

23D. ADDRESS

University of MD. Hosp.

24A. BURIAL CREMATION,  
REMOVAL (Specify)  
BURIAL

24B. DATE

12/16/72

24C. NAME OF CEMETERY OR CREMATORY

Arbutus Memorial Park

24D. LOCATION

(City, town, or county)

(State)

Arbutus, Maryland

21227

25A. DATE REC'D BY HEALTH DEPT.

DEC 18 1972

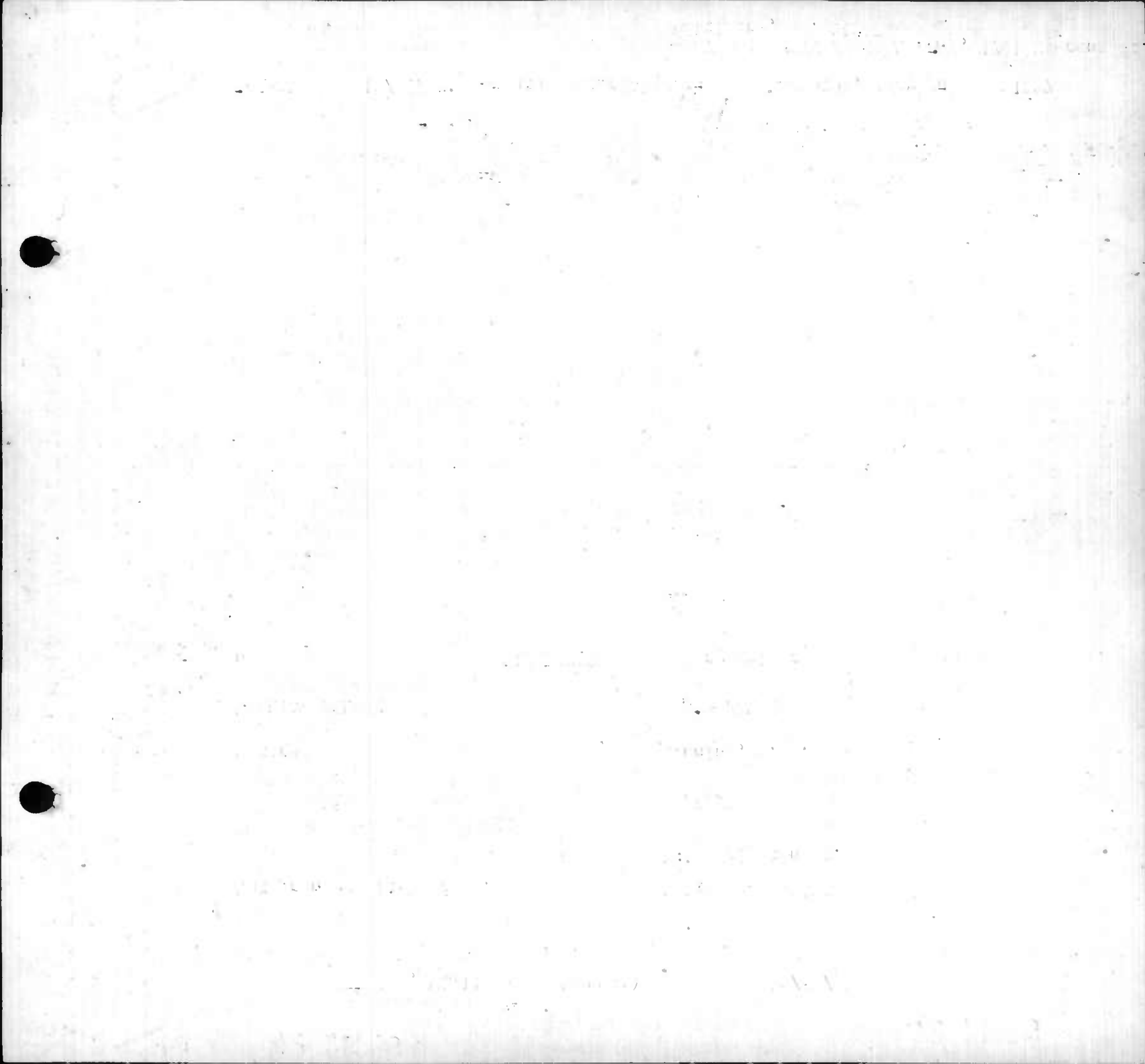
25B. NAME OF REGISTRAR

*[Signature]*

25C. FUNERAL DIRECTOR

MORTON & DYETT FUNERAL HOME, 1701 Laurens St.  
Baltimore, Md. 21217

ADDRESS





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-6261

72 11987

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 72 11987

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

STATE OF MARYLAND - DECEASED  
*Frailing, Albert (Parker)*

2. DATE AND HOUR OF DEATH

*12-16-72 8-8 P.M.*

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

*46 Lutheran*

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE B. COUNTY

*MD 1604*

C. CITY OR TOWN D. INSIDE CITY LIMITS?

*Balto* YES ☐ NO ☐

E. STREET AND NUMBER

*1918-Riggs Ave*

5. SEX

*F*

6. RACE

*N*

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

*10-20-99*

9. AGE (in years)

*73*

If Under 1 Yr. Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

*Aberdeen, Md.*

12. CITIZEN OF WHAT COUNTRY?

*U.S.A.*

13. FATHER'S NAME

*Lloyd Parker*

14. MOTHER'S MAIDEN NAME

*Mattie Tasco*

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

*N/A*

16. SOCIAL SECURITY NO.

*220-34-7019A*

17. INFORMANT

*Edgar Frailing-1918-Riggs Ave.*

ADDRESS

18. *410.9 I*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

*CARDIAC FAILURE*

(B) *ARREST*

DUE TO, OR AS A CONSEQUENCE OF:

*which was followed by successful resuscitation*

(C) *Post-Op*

*Post-Op*

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

*0*

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

*NO*

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

☐

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from *Dec - 10th* 19 *72* to *Dec - 16th* 19 *72* and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

*Tammy... M.D.*

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

*Dec - 16th 1972*

23C. PHYSICIAN'S NAME (Type)

*Tammy... M.D.*

23D. ADDRESS

*LUTHERAN HOSPITAL 730 REHABILITATION ST. BALTIMORE*

24A. BURIAL CREMATION, REMOVAL (Specify)

*Burial*

24B. DATE

*12-20-72*

24C. NAME OF CEMETERY or CREMATORY

*St. Calvary U. C. Cem.*

24D. LOCATION

*Aberdeen, Maryland*

(City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT.

*DEC 18 1972*

25B. NAME OF REGISTRAR

*Sidney... M.D.*

25C. FUNERAL DIRECTOR

*Robert... M.D.*

ADDRESS

*1701-14th St.*



M-2421

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO.

72 11988

BIRTH NO. 72 11988  
STATE OF MARYLAND-DEMH1. NAME OF DECEASED  
(Type or Print)

GEORGE MICKLES

2. DATE AND HOUR OF DEATH

DECEMBER 14, 1972 6:30 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

811 PAYSON STREET

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

E. STREET AND NUMBER

811 PAYSON STREET

D. INSIDE CITY LIMITS?

YES ☒NO ☐

5. SEX

MALE

6. RACE

BLACK

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

Dec. 14, 1909

9. AGE (In years  
last birthday)

63

If Under 1 Yr.

Months: Days: Hours: Min.

If Under 24 Hrs.

Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

RETIRED

10B. KIND OF BUSINESS OR INDUSTRY

BETHLEHEM STEEL

11. BIRTHPLACE (State or foreign country)

LANCASTER, SOUTH CAROLINA

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

GEORGE MICKLES

14. MOTHER'S MAIDEN NAME

VONNIE BROOKS

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

N/A

16. SOCIAL  
SECURITY NO.

249-09-7474

17. INFORMANT

MRS. EDITH MICKLES 811 NORTH PAYSON STREET

ADDRESS

18. 153.8 I

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

Metastatic carcinoma of liver

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B) Carcinoma of colon

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

9 Months

9 Months

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

03-23-72

19B. CONDITION FOR WHICH OPERATION

Suspected Carcinoma (GI)

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (1) (this hospital) attended the deceased from September 22, 1972 to December 14, 1972,  
that (1) (we) lost saw the deceased alive on December 14, 1972 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Samuel R. Owings, Jr.

DEGREE

Attending  
Phys. ☒Med.  
Director ☐Staff  
Phys. ☐

23B. DATE SIGNED

12-15-72

23C. PHYSICIAN'S  
NAME (Type)

SAMUEL R. Owings, Jr.

23D. ADDRESS

909-11 N. Carey St. 21217

DEGREE

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

12-22-72

24C. NAME OF CEMETERY OR CREMATORY

Garden of Hope

24D. LOCATION

Finksburg, Md

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

DEC 18 1972

25B. NAME OF REGISTRAR

Andrew R. Houston

25C. FUNERAL DIRECTOR

Robert D. Dyett F.H.

ADDRESS

1701 - Havens St.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

THE UNIVERSITY OF CHICAGO  
LIBRARY

1000  
1000

1000  
1000

1000  
1000

1000  
1000

1000  
1000

1000  
1000

1000  
1000

1000  
1000

1000  
1000

F-6231

72 11989

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

72 11989

BIRTH NO.

1. NAME (Type or Print) ~~STATE OF MARYLAND - DEME~~  
*FORREST, James T.*

2. DATE AND HOUR OF DEATH

*12-15-72**7:45 A.M.*

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)*46 LUTHERAN Hospital  
Baltimore, Md. 21216*4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE B. COUNTY*MARYLAND**1606*

C. CITY OR TOWN

*Baltimore*

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

*3026 HARLEM AVE*

5. SEX

*M*

6. RACE

*B*7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☒

8. DATE OF BIRTH

*3-10-25*9. AGE (In years  
last birthday)*47*If Under 1 Yr.  
Months DaysIf Under 24 Hrs.  
Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

*North Carolina*

12. CITIZEN OF WHAT COUNTRY?

*U. S. A.*

13. FATHER'S NAME

*Edward Forrest*

14. MOTHER'S MAIDEN NAME

*Nannie Francis*15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)*N/A*16. SOCIAL  
SECURITY NO.

17. INFORMANT

*Robert Forrest*

ADDRESS

*1924 Payson St*18. *436.01*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

*Acute Cardiorespiratory**Arrest**5 min.*

(B)

DUE TO, OR AS A CONSEQUENCE OF:

*Acute Cerebrovascular Accident**24-48 hr.*

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).*Hypertension*

19A. DATE OF OPERATION

*2*19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

*Yes*20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (Indify medical examined)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from *12/14/1972* to *12/15/1972*  
that (I) (we) last saw the deceased alive on *12/15/1972* and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

*S. S. DONGRE*

DEGREE

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

*12/14/72*23C. PHYSICIAN'S  
NAME (Type)*S. S. DONGRE*

DEGREE

23D. ADDRESS

*730, Ashburn Sr. Balto. Md. 21216*24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

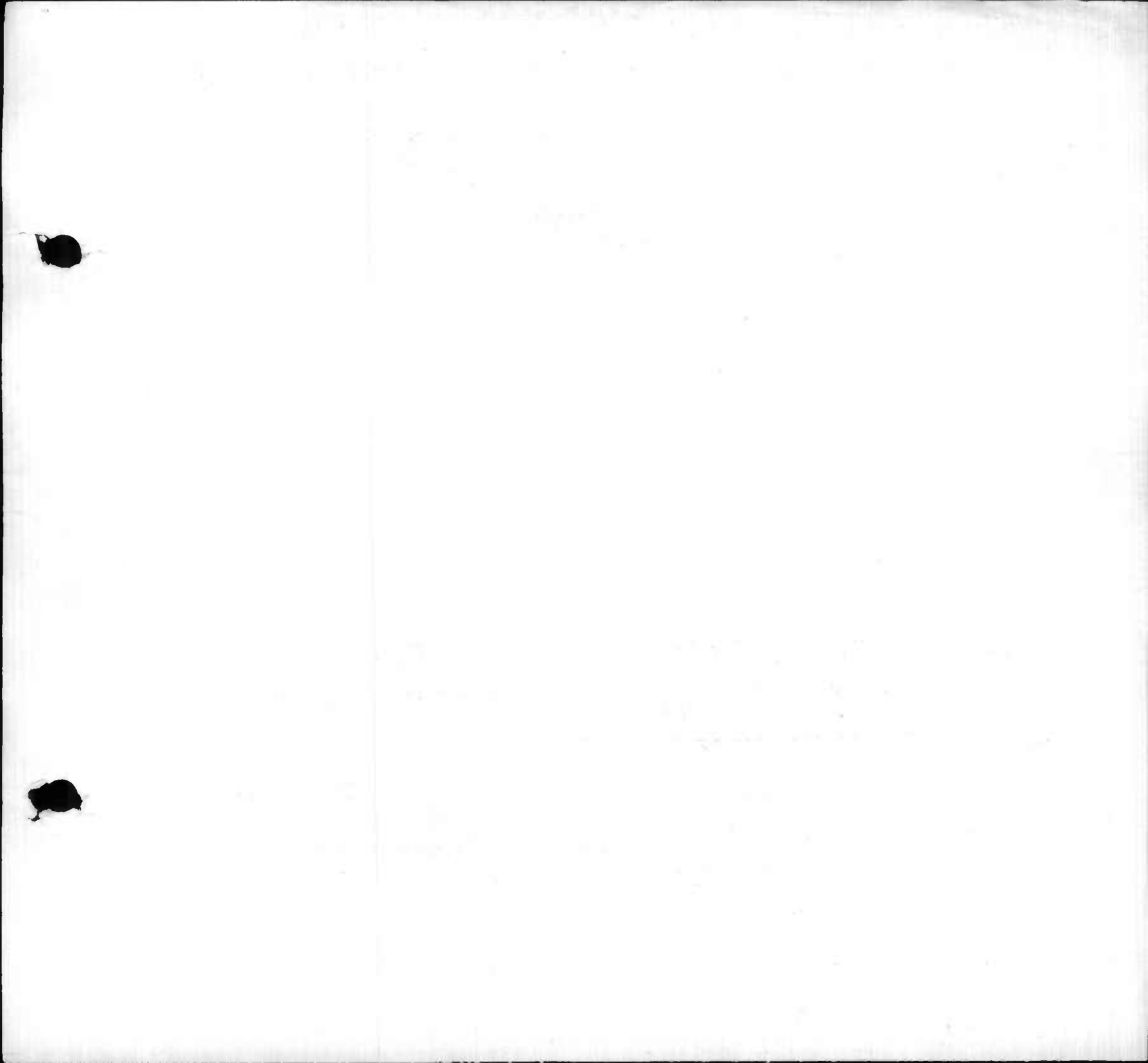
VS 150-REV. 1/1/68

DEC 18 1972

*Sidney H. H. H.**Moore-Dyett F.H. 101-Hawens St*

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



1  
B-630

72 11990

BALTIMORE CITY HEALTH DEPARTMENT

72 11990

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

STATE OF MARYLAND-DECEASED

1. NAME OF DECEASED (Type or Print) <b>Tyrone Bird</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 12 14 72 9:20 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (If not in hospital or institution, give street address or location) <b>602 N. Gilmore Street</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 14 72 9:20 P.M.	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1603</b>	
9. DATE OF BIRTH <b>12/26/36</b>		10. AGE (In years last birthday) <b>36</b>	
11. BIRTHPLACE (State or foreign country) <b>Union City, S C</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Joe Byrd</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	
15. MOTHER'S MAIDEN NAME <b>L Willie</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT <b>M. Rudy Harris, 1605 Riggs Ave</b>	

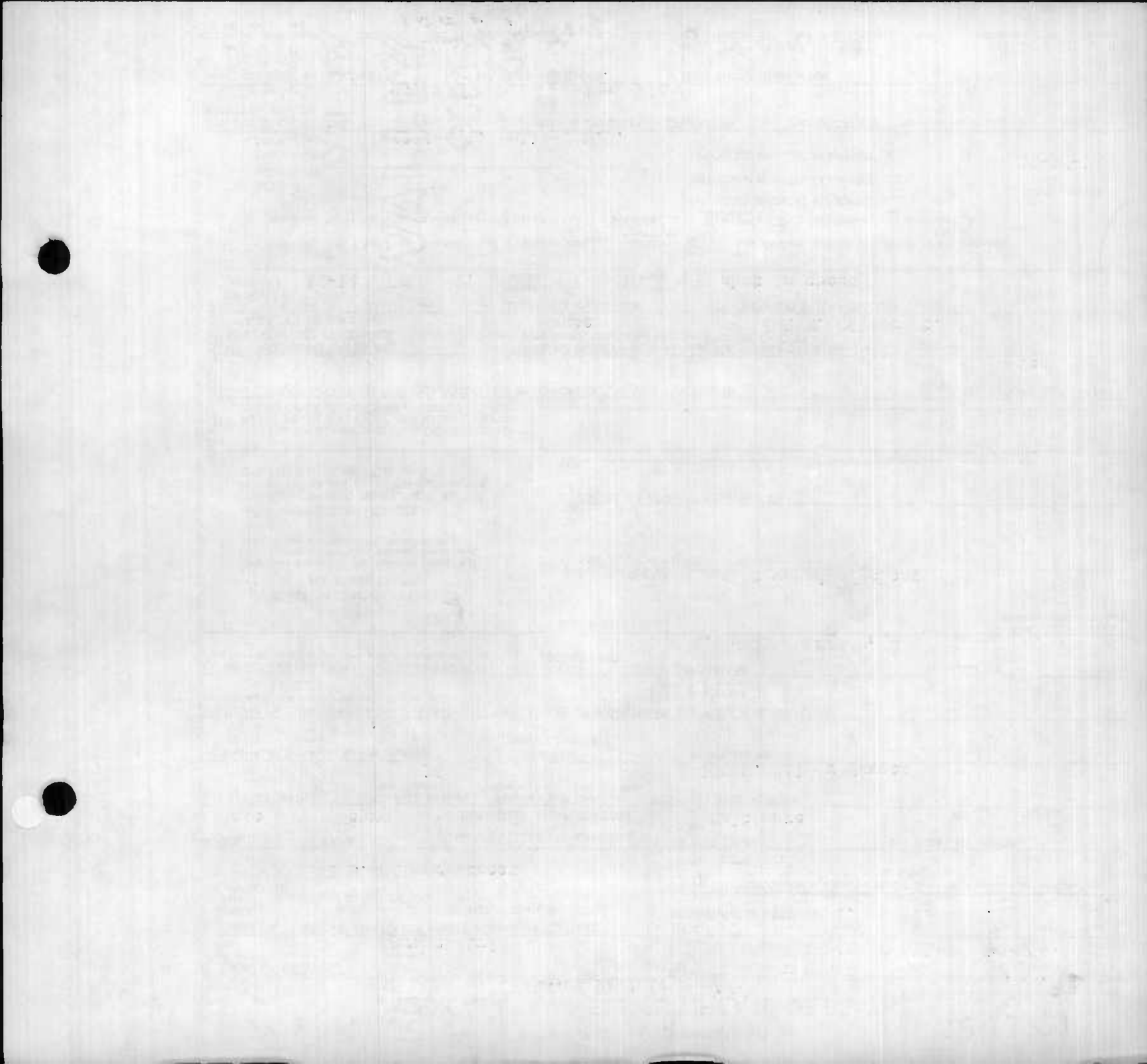
MEDICAL CERTIFICATION	19. <b>E965X</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE <b>Gunshot wound of chest</b> DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					

20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>Yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>House</b>		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>602 N. Gilmore St. 1603</b>	
22D. TIME OF INJURY (APPROX.) Month Day Year Hour <b>12-14 72 P. m.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>shot in chest</b>	

23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>12-15-72</b> ACTUAL SIGNATURE <b>W P Mulloy</b> M.D. EXAMINER'S NAME (Type) <b>William P. Mulloy, M.D.</b>					
---	--	--	--	--	--

24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/21/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Union City</b>		24D. LOCATION (City, town, or county) (State) <b>South Carolina</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 18 1972</b>		25B. NAME OF REGISTRAR <b>Sidney J. D... N 8715.1</b>		25C. FUNERAL DIRECTOR <b>Adolphus Halstead</b>		ADDRESS <b>1206 W North Ave</b>	



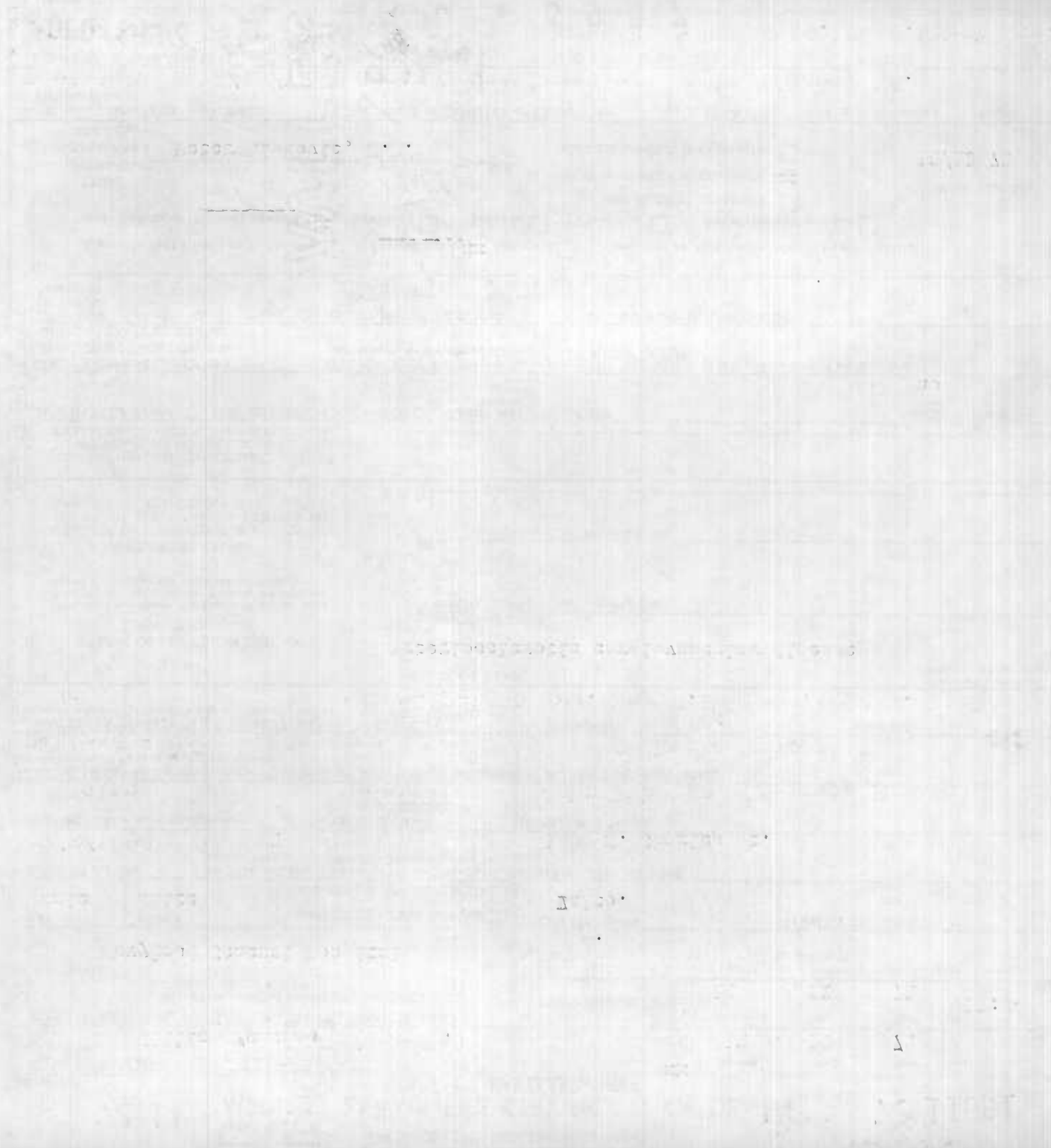


## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Ladislaus William Fuhrman (Furman)</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month <b>12</b> Day <b>12</b> Year <b>72</b> Hour <b>M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>48 Maryland General Hospital</b>		3. DATE PRONOUNCED DEAD Month <b>12</b> Day <b>12</b> Year <b>72</b> Hour <b>11:00</b> P.M.	
6. SEX <b>male</b>		7. RACE <b>White</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>2/2/1890</b>		10. AGE (in years last birthday) <b>82</b>	
11. BIRTHPLACE (State or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>Doubtful</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Cook</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Caterer</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>109-12-3523</b>	
18. INFORMANT <b>Wife:</b>		ADDRESS <b>21201 Mrs. Mary R. Fuhrman, 1800 N. Charles St.</b>	
19. <b>412.41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(A) IMMEDIATE CAUSE</b> DUE TO, OR AS A CONSEQUENCE OF: <b>(B)</b> DUE TO, OR AS A CONSEQUENCE OF: <b>(C)</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Peter Lipkovic, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Peter Lipkovic, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>12/13/72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/16/72</b>	
24C. NAME of CEMETERY or CREMATORY <b>Green Mount Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 18 1972</b>		25B. NAME OF REGISTRAR <b>Andrew B. ...</b>	
25C. FUNERAL DIRECTOR <b>STEWART &amp; MOWEN CO.</b>		ADDRESS <b>108 W. North Ave. 21201</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 11592		REG. NO. 72 11592	
CERTIFICATE OF DEATH							
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>GEORGE JOSEPH KHYATT</b> <i>George J. Khyatt</i>		2. DATE AND HOUR OF DEATH <b>DECEMBER 15, 1972 6:45 AM.</b>		STATE OF MARYLAND-DEME	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <b>MARYLAND GENERAL HOSPITAL</b>				C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>MARYLAND GENERAL HOSPITAL</b>				E. STREET AND NUMBER <b>15 W. CHASE STREET</b> <i>15 WEST CHASE STREET</i>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>07-13-79</b>	9. AGE (In years last birthday) <b>93 (93)</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Ret'd</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Importer-Rugs, etc</b>		11. BIRTHPLACE (State or foreign country) <b>Lebanon Lebanon</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Khyatt</b>				14. MOTHER'S MAIDEN NAME <b>Sadie Kawaja</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-32-1428</b>		17. INFORMANT <b>Daughter:</b> <b>XXXXX Virginia K. Horsey,</b>		ADDRESS <b>15 W. Chase 21201</b>	
18. <b>412.41</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <b>Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>COPD</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>ASCVD</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>MANY YEARS</b> <b>2 weeks</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <b>Dec. 18, 1972</b> to <b>Dec. 15, 1972</b> that (1) (we) last saw the deceased alive on <b>Dec. 15, 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Newton W. Rogers MD</i>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>12/15/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>NEWTON W. ROGERS M.D.</b>				23D. ADDRESS <b>MARYLAND GENERAL HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/18/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Laurel Grove Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Totowa, New Jersey</b>	
25A. DATE RECEIVED BY HEALTH DEPT. <b>DEC 18 1972</b>		25B. NAME OF REGISTRAR <i>Adrienne W. Rogers</i>		25C. FUNERAL DIRECTOR <b>STEWART &amp; NOWEN CO.</b> ADDRESS <b>108 W. North Ave.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 72 11993		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 11993	
CERTIFICATE OF DEATH				STATE OF MARYLAND - DECEASED	
1. NAME OF DECEASED (Type or Print) <b>FOO DER - aka: Lum Wee Ho, Chas</b>		2. DATE AND HOUR OF DEATH <b>12-11-1972 4:15 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>Md. 2607</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) <b>Baltimore</b>			
5. SEX <b>Male</b>		6. RACE <b>Oriental</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>12-27-1910</b>		9. AGE (In years last birthday) <b>61</b>		10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Partner</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Noodle Mfg.</b>		11. BIRTHPLACE (State or foreign country) <b>Hong Kong</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Kin Der</b>			
14. MOTHER'S MAIDEN NAME <b>Won Ho</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>213-34-4682</b>		17. INFORMANT Son: Philip Der, 1652 E. Belvedere Ave. 21212			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cancer of Liver</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indefinite medical examined) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>10-26</b> 19 <b>72</b> to <b>12-11</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>12-11</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>A. J. Sequeira</b>		23B. DATE SIGNED <b>12-11-1972</b>		23C. PHYSICIAN'S NAME (Type) <b>A. J. Sequeira</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/15/72</b>		24C. NAME of CEMETERY or CREMATORY <b>Lorraine Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Woodlawn, Balto. Co., Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 18 1972</b>			
25B. NAME OF REGISTRAR <b>Sidney M. ...</b>		25C. FUNERAL DIRECTOR <b>STEWART &amp; MOWEN CO.</b>			
25D. ADDRESS <b>108 W. North Ave.</b>		25E. ADDRESS <b>21201</b>			

12-29-1972 - Correction form from Funeral Director and Policy #5082056 - Sun Life Assurance  
Co. of Canada, dated October 2, 1958 shows date of birth as December 27, 1910.

hs



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

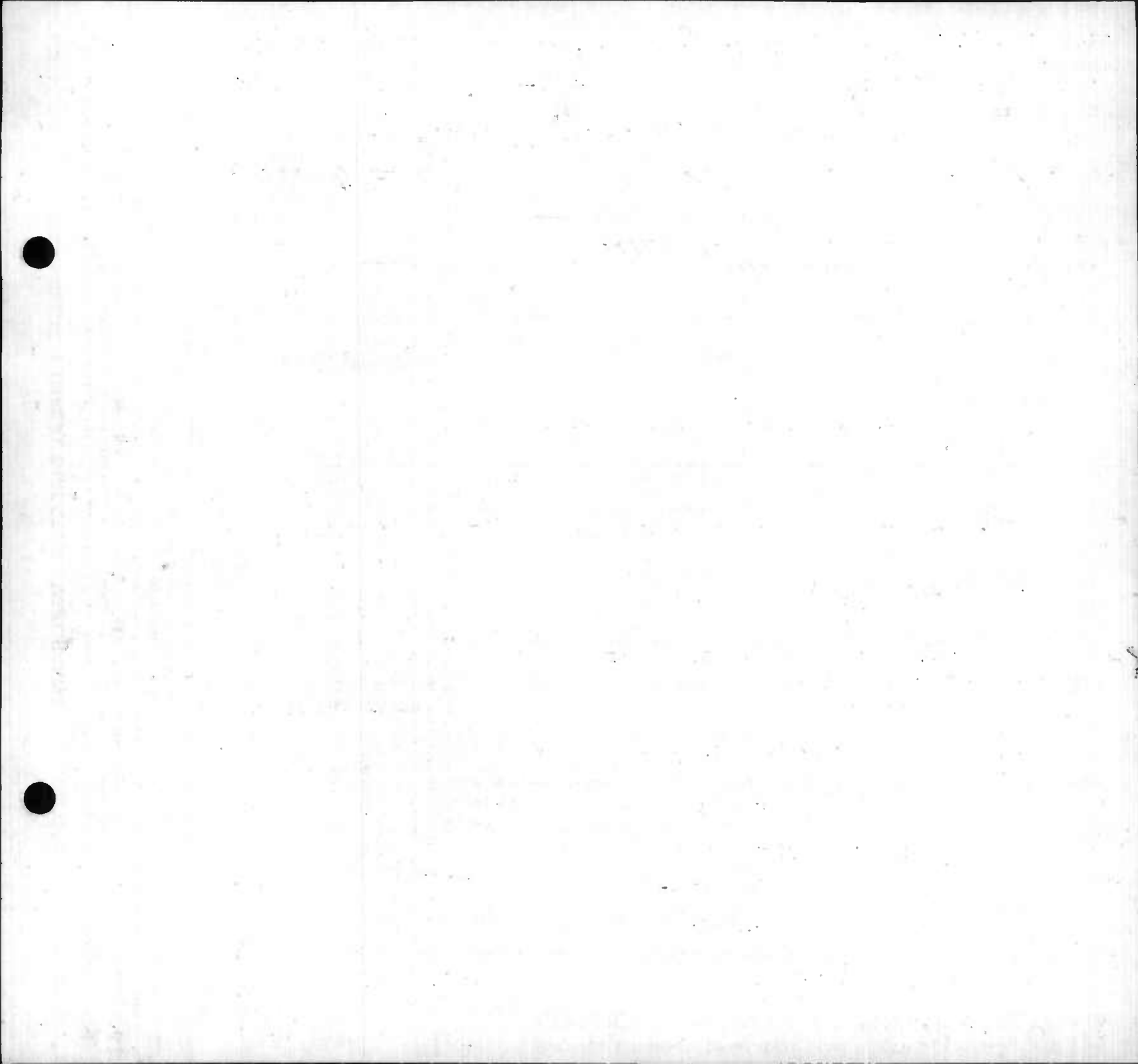
72 11891				Baltimore City Health Department				72 11894			
BIRTH NO.				CERTIFICATE OF DEATH				REG. NO.			
1. NAME OF DECEASED (Type or Print) <b>HOWARD H. WILLIAMS</b>				2. DATE AND HOUR OF DEATH <b>DEC 17<sup>th</sup>, 1972 1:22 P. M.</b>				STATE OF <b>MARYLAND</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>903</b>							
FULL NAME OF HOSPITAL OR INSTITUTION <b>THE UNION MEMORIAL HOSP.</b>				C. CITY OR TOWN <b>BALTIMORE</b>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER <b>642 Mc KEWIN AVE</b>							
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>09-14-89</b>		9. AGE (In years last birthday) <b>83</b>		11. Under 1 Yr. Months: Days		11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MECHANIC</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>AUTOMOBILE</b>				11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOHN HENRY GIPE</b> <del>UNKNOWN</del>				14. MOTHER'S MAIDEN NAME <b>MARY MARGARET MORRIS</b> <del>UNKNOWN</del>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>217-24-9260</b>		17. INFORMANT <b>MR GEORGE L. WILLIAMS</b>				ADDRESS <b>(SAME)</b>	
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>POSS ACUTE MYOCARDIAL INFARCT</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>SEVERE ARTERIO SCLEROSIS</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).											
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from <b>DEC 17<sup>th</sup></b> 19 <b>72</b> to <b>DEC 17<sup>th</sup></b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>DEC 17<sup>th</sup></b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <b>[Signature]</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>12/17/72</b>			
23C. PHYSICIAN'S NAME (Type) <b>ANDRES E. SUAREZ M.D.</b>				23D. ADDRESS <b>33RD AND CALVERT STS BALTO MD.</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-20-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 18 1972</b>				25B. NAME OF REGISTRAR <b>[Signature]</b>				25C. FUNERAL DIRECTOR ADDRESS <b>Henry W. Jenkins Sons 4905 York Rd. Balto., Md. 21212</b>			

THE UNIVERSITY OF CHICAGO  
LIBRARY

CHICAGO, ILL. 60637

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

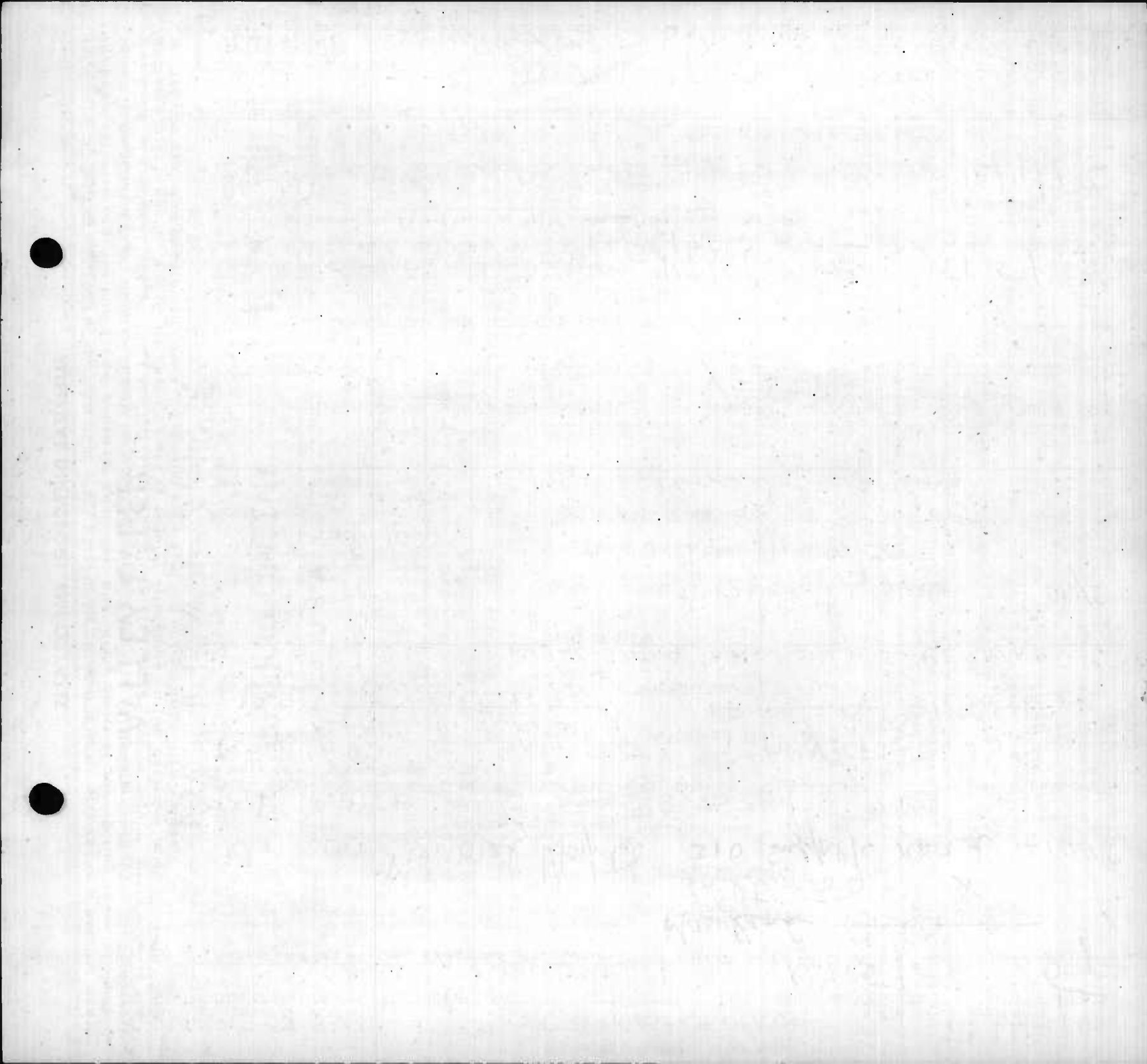
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 11995	
72 11995				STATE OF MARYLAND - DUMM	
BIRTH NO.				2	
1. NAME OF DECEASED (Type or Print) Rhea P. Clasby			2. DATE AND HOUR OF DEATH Dec. 17, 1972 12 30/4 M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Gould Convalesarium			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2778 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 500 Harwood Ave. 21212		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-21-1882	9. AGE (In years last birthday) 90	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME David Summers		
14. MOTHER'S MAIDEN NAME Julia			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 212-07-6432			17. INFORMANT 417 Charter Oak Ave. 21212 Miss Blanche S. Farrow		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 4/12/31 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Gangrene detritus of foot & battle 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH yes yes months		
22. I certify that (I) (the hospital) attended the deceased from 10/27/1972 to 12/17/1972, that (I) (we) last saw the deceased alive on 12/15/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Albert B. Bradley			23B. DATE SIGNED 12/18/72		
23C. PHYSICIAN'S NAME (Type) Albert B. Bradley M. D.			23D. ADDRESS 4900 Belair Road		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-19-72	24C. NAME OF CEMETERY or CREMATORY Baltimore		24D. LOCATION (City, town, or county) (State) Baltimore, Md.
25A. DATE REC'D BY HEALTH DEPT. DEC 18 1972		25B. NAME OF REGISTRAR Indy Jenkins		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 11996	
BIRTH NO. 72 11996				STATE OF MARYLAND-DEATH	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Richard C. Bernard			12/15/72 5:00 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital			A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 310 Suffolk Road 21218		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-20-99	9. AGE (In years last birthday) 73	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ATTY. ARCHITECT
11. BIRTHPLACE (State or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME ALFRED D. BERNARD NOT AVAILABLE			14. MOTHER'S MAIDEN NAME MARTHA CONSTABLE NOT AVAILABLE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES			16. SOCIAL SECURITY NO. 213-10-5151A		
17. INFORMANT MRS. EMILY S. BERNARD (SAME)			ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE Possible H.1 Possible dissection of aorta (B) DUE TO, OR AS A CONSEQUENCE OF: (C) possible pneumonia APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 DAYS		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 12/12/1972 to 12/15/1972 that (we) last saw the deceased alive on 12/15/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE Q. W. Joyee, M. D.				23B. DATE SIGNED 12/18/72	
23C. PHYSICIAN'S NAME (Type) Q. W. Joyee, M. D.				23D. ADDRESS Union Memorial Staff	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-19-72		24C. NAME OF CEMETERY or CREMATORY Greenmount Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. DEC 18 1972		25B. NAME OF REGISTRAR Henry W. Jenkins Sons	
25C. FUNERAL DIRECTOR ADDRESS 4905 York Rd. Baltimore, Maryland 21212					





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHREG. NO. 72 11997  
STATE OF MARYLAND - DIME

BIRTH NO. 72 11997

1. NAME OF DECEASED  
(Type or Print)

MAMIE S. MUNDER

2. DATE AND HOUR OF DEATH

12-16-72

6:30 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

90 Edgewood N.H.

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN

Baltimore

E. STREET AND NUMBER

1102 E. Belvedere Ave.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

5. SEX

F

6. RACE

W

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

7/20/1879

9. AGE (In years  
last birthday)

93

If Under 1 Yr.  
Months: Days:If Under 24 Hrs.  
Hours: Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Homemaker

10B. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Wash. D. C.

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Thomas N. Steep

14. MOTHER'S MAIDEN NAME

?

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

217-50-2488

17. INFORMANT

ADDRESS

Mrs. L. V. Godine, 4300 N. Charles St.

18. 7/24/1

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) Myocardial Failure

5 days

(B) Ventricular Fibrillation

2 weeks

(C) Chronic Myocarditis

15 yrs

Arteriosclerotic C-V disease; senility

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from July 1970 to Dec. 16, 1972,  
that (I) (we) last saw the deceased alive on Dec. 14, 1972 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

23C. PHYSICIAN'S  
NAME (Type)

Harold Harbold

MD

Attending  
Phys. ☒Med.  
Director ☐Staff  
Phys. ☐

23B. DATE SIGNED

Dec. 16, 1972

23D. ADDRESS

4706 Harford Rd., Balto., Md.

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Cremation

24B. DATE

12-16-72

24C. NAME OF CEMETERY or CREMATORY

Loudon Park

24D. LOCATION

Baltimore

(City, town, or county)

(State)

Md.

DEC 18 1972

HEALTH DEPT.

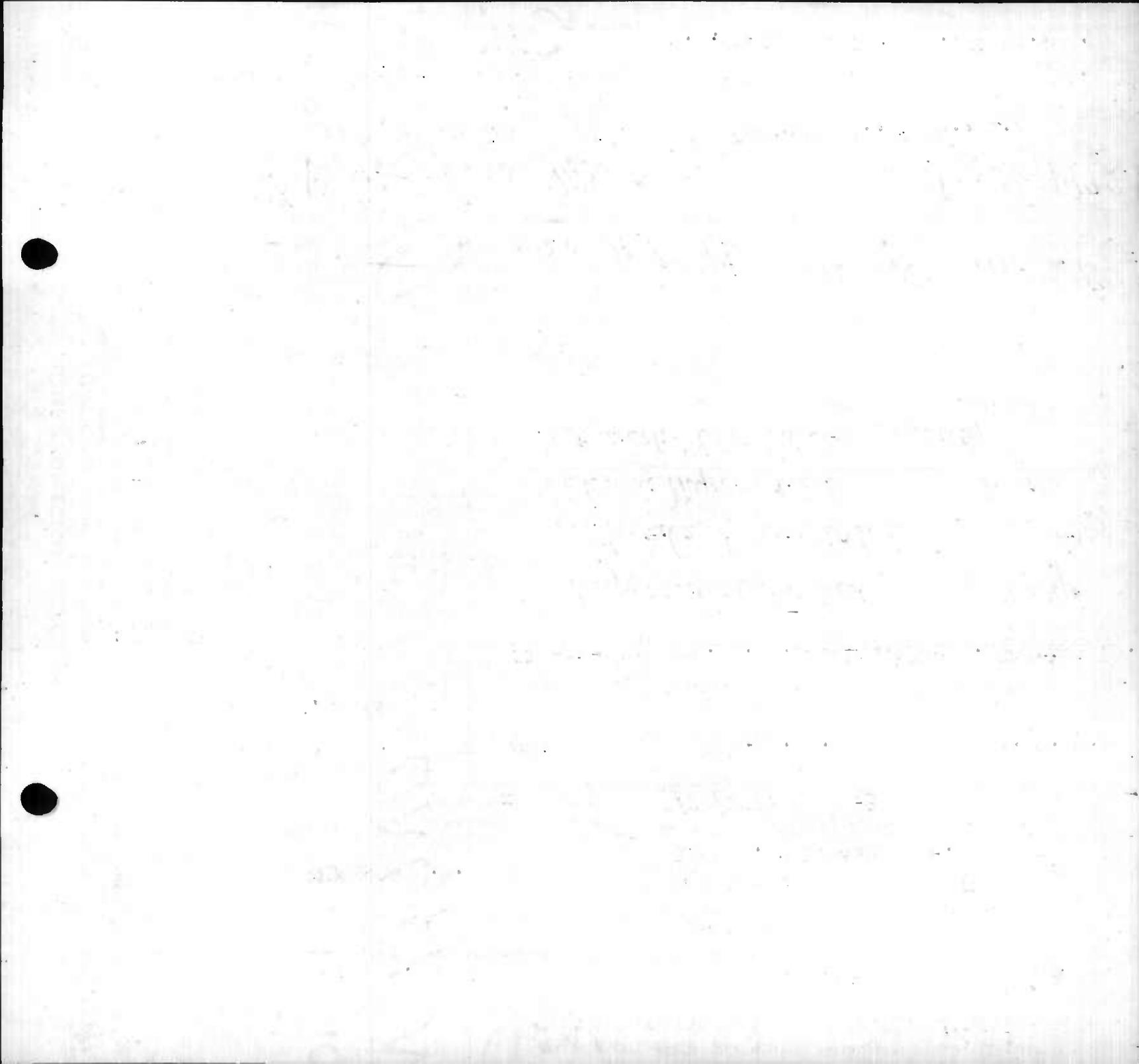
25A. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

H. W. Jenkins &amp; Sons Co., Balto., Md.

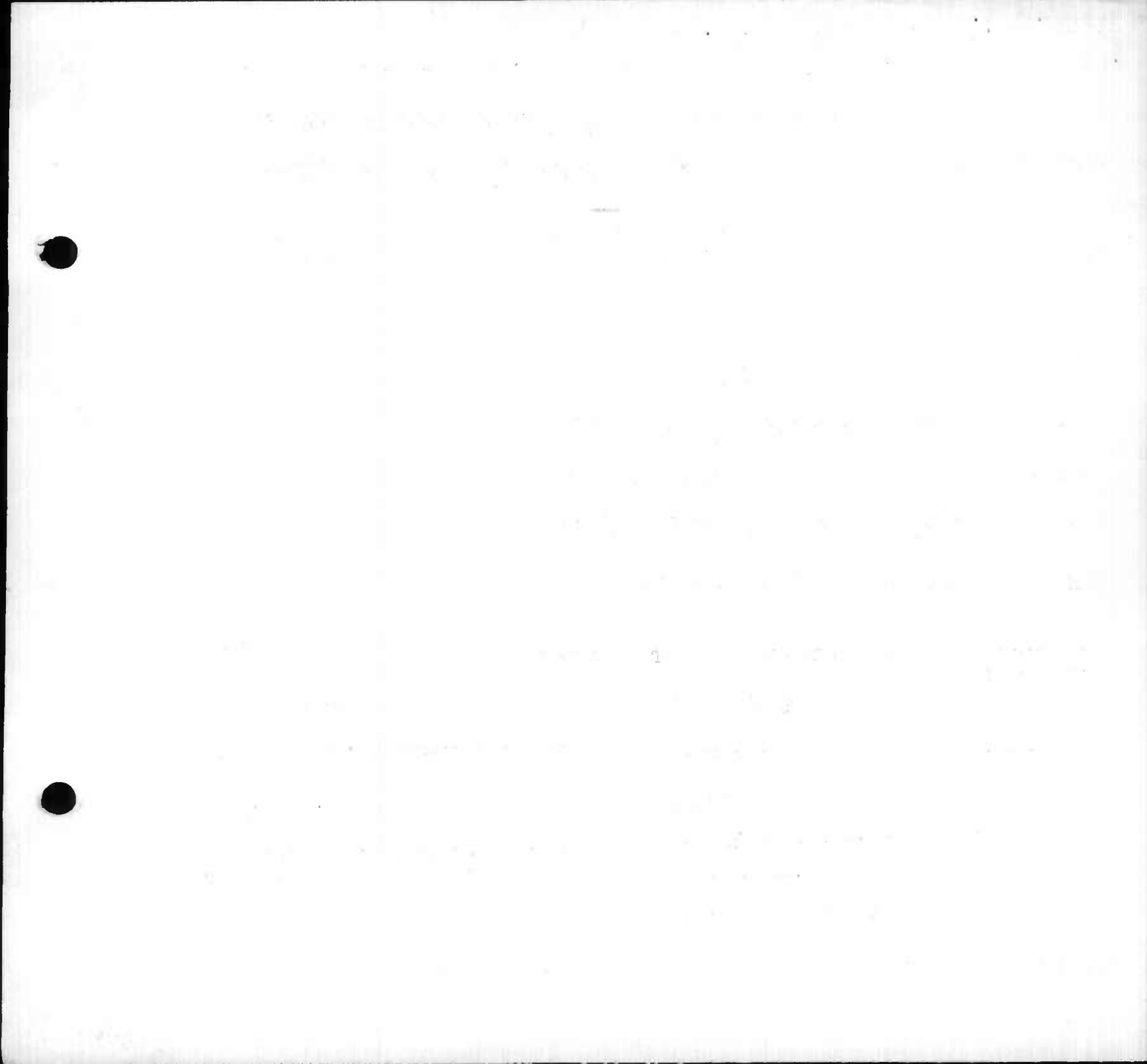
ADDRESS





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72 11998</u> STATE OF MARYLAND - DIME	
BIRTH NO. <u>72 11998</u>		1. NAME OF DECEASED (Type or Print) <u>Dorothy Murphy Waller</u>		2. DATE AND HOUR OF DEATH <u>December 15, 1972</u> <u>10:20 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Jenkins Memorial Hospital</u> <u>1000 Caton Ave. Baltimore, Md. 21229</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Balto. City</u> C. CITY OR TOWN <u>Balto., Md.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>524 N. Charles Street</u> <u>21201</u>		
5. SEX <u>F.</u>	6. RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/7/1893</u>	9. AGE (In years last birthday) <u>79</u>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Operated Balto. Duplicating Service</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Owen Murphy</u>			14. MOTHER'S MAIDEN NAME <u>Margaret Golden</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>220-28-7483</u>	17. INFORMANT <u>Jenkins Memorial Hospital</u> <u>1000 Caton Ave. Balto., Md.</u>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE <u>CEREBRAL VASCULAR ACCID</u> <u>6 HRS</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Arterio-Sclerotic Cardio-Vascular Disease</u> <u>10 YRS.</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>GEN. OSTEOARTHRITIS</u> <u>10 YRS.</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>COLITIS - HYPOPROTEINEMIA</u>			<u>8 MOS</u>		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <u>OCT. 19</u> <u>1965</u> to <u>DEC. 15</u> <u>1972</u> that (I) (we) last saw the deceased alive on <u>DEC. 15</u> <u>1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>John F. Hartman M.D.</u>			23B. DATE SIGNED <u>DEC. 15, 1972</u>		23C. PHYSICIAN'S NAME (Type) <u>JOHN F. HARTMAN M.D.</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>12-18-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>St. Ignatius</u>
24D. LOCATION <u>Hickory,</u>			24E. ADDRESS <u>Md.</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 18 1972</u>		25B. NAME OF REGISTRAR <u>Lidney Weston</u>		25C. FUNERAL DIRECTOR <u>CH. W. Jenkins &amp; Sons Co.</u>	
VS 150-REV. 1/1/68		4905 York Road Balto., Md. 21212			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Bodily burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				STATE OF MARYLAND - DEPT.	
72 11999				72 11999	
BIRTH NO.				REG. NO.	
1. NAME OF DECEASED (Type as Print) <b>BRAUN, Teresa Mary</b>			2. DATE AND HOUR OF DEATH <b>12/14/72</b> <b>9:47</b> P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Keswick Home for Incurables of Baltimore City</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>City of Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3232 Abell Ave. 21218</b>		
5. SEX <b>Female</b>	6. RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 23, 1895</b> <b>77</b>	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hosp. Admitting Officer, UMH</b>			11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Jacob Braun</b>			14. MOTHER'S MAIDEN NAME <b>Katherine Lohrum</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>212-32-1161</b>		17. INFORMANT <b>KESWICK FILES</b>
18. <b>174-X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma rt breast with generalized metastasis</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 1/2 yrs</b>		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>April</b> 19 <b>70</b> to <b>14 Dec</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>14 Dec</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Harold P. Breul MD</b>					23B. DATE SIGNED <b>14 Dec 72</b>
23C. PHYSICIAN'S NAME (Type) <b>Harold Breul M. D.</b>			23D. ADDRESS <b>Keswick Home</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-18-72</b>	24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 18 1972</b>		25B. NAME OF REGISTRAR <b>Sidney Johnston</b>		25C. FUNERAL DIRECTOR <b>H. W. Jenkins &amp; Sons Co.</b> <b>1905 York Road Balto., Md. 21212</b>	

WICKLIFFE

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 72 12000				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 12000	
CERTIFICATE OF DEATH				STATE OF MARYLAND-DEATH			
1. NAME OF DECEASED Type or Print <b>ANDREW ERNST</b>				2. DATE AND HOUR OF DEATH <b>12/13/72</b> <b>10:55A</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>MARYLAND GEN. HOSP.</b> FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>827 LINDEN AVE.</b> <b>48 BALTO., MD. 21201</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>702</b>			
5. SEX <b>M</b> 6. RACE <b>W</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>2/12/1895</b> 9. AGE (in years last birthday) <b>77</b>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FIREMAN</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Baltimore City</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				13. FATHER'S NAME <b>HENRY ERNST</b>			
14. MOTHER'S MAIDEN NAME <b>MARY HEISE</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			
16. SOCIAL SECURITY NO. <b>218-26-6874</b>				17. INFORMANT (WIFE) (nee Spence) <b>MARGARET ERNST</b> ADDRESS <b>SAME</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>185X</b> <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <b>Cardiorespiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Blood loss, hemo + chemo</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Remainder of Prostate</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>25 minutes (?)</b> <b>days (?)</b> <b>years</b>				II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <b>12-12</b> 19 <b>72</b> to <b>12-13</b> 19 <b>72</b> that (1) (we) last saw the deceased alive on <b>12-13</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>man</b> <b>MD</b> DEGREE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>12/13/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>PT MALCARI</b> <b>MD</b> DEGREE				23D. ADDRESS <b>827 LINDEN AVE., BALTO., MD. 21201</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/18/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Mde.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 18 1972</b>		25B. NAME OF REGISTRAR <b>Sidney</b>		25C. FUNERAL DIRECTOR <b>Schumaker Funeral Home, Inc.</b> ADDRESS <b>6339 Brehms Lane</b>			

